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DEPARTMENTS OF LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION, AND RELATED AGENCIES
APPROPRIATIONS FOR 2002

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS
FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION, AND RELATED AGENCIES

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED
AGENCIES APPROPRIATIONS FOR 2002

Wednesday, May 2, 2001.

OFFICE OF THE SECRETARY

WITNESS

HON. TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN
SERVICES

Chairman's Statement

Mr. Regula. Good morning and welcome, Mr. Secretary.

You have a somewhat larger budget than you did in Wisconsin, I see. You have jurisdiction over \$468 billion. That's a fairly sizeable challenge.

Secretary Thompson. Only five countries in the world are bigger.

Mr. Regula. Is that right? You even have more than Secretary Rumsfeld with broad responsibilities including human service programs, Head Start, child care, LIHEAP and a wide array of health programs. I've said this before--the Bible says there's two great commandments. One is to love the Lord and the second is to love your neighbor. We're the ``Love Your Neighbor Committee,'' and you're the ``Love Your Neighbor Secretary'' because there isn't a person in America that's not touched in some way or another by what you're doing in that agency.

I think the President's budget recommendations outline an ambitious agenda for you and your department. There are several new initiatives, expansion of programs and I see there's a redirection of about \$1.3 billion of departmental spending, which I assume gives you some latitude in the way you approach it.

I was very pleased to see the President's recommendations in the areas of health research, the community health centers, I'm sure you had those in your State, the substance abuse treatment prevention and child care. I note that there's over \$400 million requested for new programs that help some of the most vulnerable people in our society. So you have an enormous challenge and an enormous opportunity to leave a great legacy for people.

We welcome you this morning and we welcome the Chairman of the Full Committee. I have to tell you, I think it's the first time he's been here, so that's a tribute to you.

Mr. Secretary, we'll put your full statement in the record and you can summarize as you choose.

SECRETARY'S STATEMENT

Secretary Thompson. Thank you so very much, Chairman Regula.

First off, let me thank you for your kindness and consideration and also Chairman Young. I'd also like to thank my home State Ranking Minority Member, Congressman Dave Obey, who will be coming later. I'm honored to appear in front of you and all the distinguished members of this tremendous Committee.

And it truly is love your neighbor. This Department, as you know, Chairman, actually interacts with every American, every man, woman and child somehow is affected by the Department of Health and Human Service budget. So it is an awesome responsibility that I have and that you have. Together, with bipartisanship, I think we do a great job and leave a great legacy and help a lot of Americans improve their quality of life.

I'm confident that a review of the full details of our budget will demonstrate that we are proposing a very balanced, responsible earpiece to building a strong and healthy America. The budget before you today keeps the promises the President has made, and proposes new and innovative solutions for meeting the challenges that face this great Nation.

Our proposal increases support for America's children and families. It enhances the groundbreaking research being sponsored by the National Institutes, which I know you and several other members have been up to see.

Mr. Regula. We're planning to go back, incidentally, to get the members that missed the first trip.

Secretary Thompson. It's exciting to be up there and see what's going on. It also begins the modernization of Medicare and expands access to health care. It reforms the way the Department's operations are managed or will be managed. Mr. Chairman, the total HHS request for fiscal year 2002 is \$468 billion. The discretionary component totals \$55.5 billion. The amount before this Committee totals \$300 billion in budget authority, of which \$51.4 billion is discretionary.

I know some of you have concerns about various decisions in the Department's budget, notably child care, AIDS and providing care for the uninsured. I'm here today to assure you that these are top priorities for this Administration and the whole Department of Health and Human Services.

I would also urge you to look at the budget as a whole, and not just individual lines at individual agencies. Look at issues as a whole and you will see that we will have better collaboration among agencies within the Department to make a more concerted and coordinated effort on an array of issues that can better serve all Americans.

President Bush recognizes the importance of investing in our children. The HHS budget reflects the commitment. Overall, this budget provides nearly \$3 billion in increased spending for children's programs through this Department. The budget also includes increases for both existing programs as well as investments in a number of new programs designed to fulfill President Bush's commitment to making sure that no child is left behind.

One of the most important things that we as a Government

can do to help working families, especially those trying to move from dependency to the work force, is assist them in obtaining child care. The President has requested a total of \$2.2 billion for the child care and development block grant, which requires a 10 percent increase. And as proposed, to specifically dedicate \$400 million of that \$2.2 billion for after school certificates within the block grant. These certificates would help low income working parents to pay for the costs of after school care for up to an additional 500,000 children who are under 19 years of age.

These after school activities are to have a strong educational component, helping children to achieve success in schools. There's also an additional \$150 million increase in spending on mandatory child care programs. Any way you look at it, these are real increases in child care.

To further strengthen American families, President Bush has proposed ambitious initiatives to promote stable families and responsible fatherhood, paternity group homes, a compassionate capital fund, and a proposal to establish a center for faith based and community initiatives within the Department. We also will increase funding for substance abuse treatment by \$100 million.

You can't talk about the health of American families without talking about women's health. This Administration recognizes the vital role that women play in the health of all of their families. Therefore, we're increasing funding for the Office of Women's Health by \$10 million to \$27 million, which is a 51 percent increase. Because we recognize that healthy women mean healthy families.

This Administration also remains committed to fighting AIDS and HIV, both at home and yes, abroad. We have a serious problem internationally. The budget includes \$10 million for AIDS and HIV programs, a 7.2 percent increase for research, treatment and prevention. It includes an 11 percent increase for international AIDS prevention as well. I hope we can discuss that later on this morning.

Along those same lines, we have joined the State Department to develop a huge task force, provide real leadership in the fight against HIV and AIDS both domestically and internationally. The President, Secretary Powell and myself are committed, and passionately so, to fight this disease on all fronts.

A top priority for this Administration is ensuring that the National Institute of Health will be able to continue to have the resources necessary to help turn these promises into a reality. The research that is conducted and supported by the NIH, and the most basic research of biological systems, to now the effort to map the human genome offers the promise of breakthroughs at preventing and treating diseases from cancer to Parkinson's to Alzheimer's. The potential that lies in these projects is why President Bush's plan to double resources for the NIH by 2003 is so vital.

The \$2.75 billion increase in this budget is the largest yet ever for NIH, and it will support an additional 34,000 research grants, the most in the agency's history. The President also has included \$200 million for asthma research, a 12 percent increase, and also \$768 million for diabetes

research, an 11.3 percent increase.

Of all these issues confronting this Department, nothing has a more direct effect on the well-being of our citizens than the quality of health care. I would like to begin today by talking about Medicare, the cornerstone of our health care system. It provides coverage to 40 million Americans and is the largest health insurer in the Nation. All of us are paying our taxes into this system, are supporting it not only for today's beneficiaries, but in the full faith and expectation that this program will be there when we need it and when our children need it, delivering health care at a price that we all can afford.

Costs for all of Medicare will nearly quadruple over the next 75 years, growing from 2.2 percent of the gross domestic product today to 8.5 percent in 2075. At the same time, revenues will only grow from 2.4 percent of GDP today to 5.3 by 2075, a huge gap.

What does this mean for the American taxpayer? Today there are nearly four workers paying for Medicare. By 2030, it will be down to two and a half to one. While modernizing Medicare is a cornerstone of our health care agenda, we're also proposing steps to strengthen the health care safety net for those most in need. Community health centers provide high quality community based care to approximately 11 million patients, 4.4 million of whom are uninsured, through a network of over 3,000 centers in rural and urban areas. The President has proposed to expand and increase the number of health care centers by 1,200 by fiscal year 2006. As a first installment of this multi-year initiative, we propose to increase funding for community health by \$124 million.

This Administration also is committed to giving States greater flexibility to manage their health programs. We also are acting to address the nursing shortage in America by increasing funding for nursing professional programs to \$82 million for the fiscal year, which is a 7 percent increase.

For any organization to succeed, it must never stop asking, as you know, Mr. Chairman, you and I have discussed this, how we can do things better. And I am committed, as Secretary, to seek new and innovative ways to improve the management of our programs. But we must also recognize that we do a disservice to all who rely on this department if we do not provide the resources necessary to effectively administer our programs. Preparing our budget, we began the process of evaluating the programs and the business practices of this Department, and yes, identifying the areas where we can do a better job of managing taxpayer resources, as well as those areas where new investments are required if we are going to successfully administer our operations.

To that end, we're investing in modernizing and increasing the efficiency of the Health Care Financing Administration. As many of you know, I am spending this whole week working out of HCFA in Baltimore. I moved my whole office up there for a week to see how HCFA's run and are making the decisions. Today, I'm taking a little time off to be with you. But I'll be back there tomorrow and Friday.

You can learn a lot by visiting HCFA. What I've learned is that HCFA is an agency that has been strapped with excess

regulations and responsibilities, without receiving the resources necessary to do its job effectively. HCFA offices are filled with hundreds of dedicated employees, but also with outdated computers and bookkeeping systems, and demands that have spread the agency too thin for too long.

HCFA needs our help now so it can help you and the American people. To help HCFA begin to meet these challenges, the budget has proposed an increase of \$100 million or 5 percent for new program management. We are dedicating \$36 million to update antiquated information technology systems, and we're working to ensure HCFA is more responsive, efficient and effective, as well as flexible in dealing with providers and States and health care providers.

Mr. Chairman, I've talked about just a few of the dozens and dozens of exciting initiatives in this budget for the Department of Health and Human Services. A more detailed list is included in the written testimony that I have already submitted.

The common thread, however, that binds all of our proposals together, is a desire to build a strong and healthy America and to improve the lives of the American people. I am prepared to work with each of you on a bipartisan basis to ensure that we develop a budget for this Department that effectively serves the national interest.

I will be happy to answer any questions that you may have, and thank you for giving me this opportunity to make those remarks.

[The statement follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Mr. Regula. Thank you, Mr. Secretary. I'm going to defer some of my questions so my colleagues, who have other committee commitments, have a chance to get them in. First of all, I want to call on our Chairman of the full Committee, who has, as he tells me, 23 years of service on this Subcommittee. I'm sure, Mr. Chairman, you've seen it grow a little bit in the amount of money.

ORGAN DONOR PROGRAM

Mr. Young. Well, Mr. Chairman, thank you very much. I wanted to include my welcome to the Secretary. When he was appointed by the President to this very important position, I was very pleased with that because of his record of public service in Wisconsin, and also the fine management decisions that he brought to Amtrak. Finally got them starting to show a little bit in the black. They still have a little way to go, but he made a big improvement. A lot of the equipment is better now, he did a really good job. So I know he's going to be very, very successful in his role as a member of the President's Cabinet.

He's a hands-on guy, I know that from experience, because we've talked about a number of things in the past that actually came about. The tobacco settlement was one of the big issues we dealt with. But early on, I think it was at the end of your

first week as Secretary, you got personally involved in the organ donor program. And that's something that is very close to my heart. You know, I have worked for years on the marrow donor program.

Give us a couple of minutes on where we're headed with the organ donor program and how successful your effort has been so far. I know it's only been a short while. But I also know that when you move, things happen.

Secretary Thompson. Well, thank you so very much, Mr. Chairman. First let me thank you for your leadership on the Subcommittee and the full Committee, and also your great support for organ donorship in America.

We have a serious problem. Seventy-six thousand Americans are waiting. We're losing about 300 individuals each and every week. There are more people being added to the list. Six thousand one hundred individuals died last year waiting for an organ. That's just not right in this compassionate country of ours.

What we have to do is we have to get the message out. Only 22,000 individuals received organs last year. Can you imagine the angst and anxiety that person has got to go through, waiting, watching the clock, wondering whether or not they're going to beat the clock, and be one of those lucky individuals to get an organ.

So what we're trying to do is we're trying to put on a lot of new initiatives. The first thing we were able to do is we were able to start a new group, employers and employees. We got the three big automobile companies, Daimler Chrysler, Ford and General Motors, with UAW, to write into their contract that they will work in a collaborative way in order to encourage employees to sign up to become organ donors. They're going to go throughout all of their factories to do so. We've got 18 companies to do that so far. We should have thousands of companies across America, every State, working with their employees.

The second thing I think we should do is I think we should recognize the tremendous amount of giving that people do give when they give an organ or marrow or whatever. And I would hope that Congress would give a Congressional gift of life medal. I think it would be a wonderful day, some day next year, if we could get five families for every Congressional district across America with one or two recipients to come to this Capitol and be able to receive a gift of life medal, to recognize what these families have done, as well as have the recipients get up and say how important it is to have a second chance.

What that would do to all of America would highlight it. It wouldn't be that much, but what a great thing it would do for you, for your constituents and for America.

The third thing, we have to get people to sign donor cards. What we have to do is we have to have them talk to their families. Because we have found that once you sign an organ donor card, if you don't talk to your family members, 50 percent of the family members will tell the doctor that they don't want to give up the organs. So it's important for you to discuss this, it's a difficult thing.

The fourth thing I would like to see happen is something I did in Wisconsin. I did the gift of life medal in Wisconsin,

and it was the most moving, emotional thing I've ever done in my life and I would hope that we could convince Congress to do the same thing.

But a young girl, Kelly Knockrimer, who is very advanced, very young age, before she turned 16, she went to her mother and said, I would like to give my organs if something would happen to me. And her mother said, well, nothing's going to happen to you, you're only 16. She got her driver's license, and she signed her driver's license.

Thirty days later, in a freak accident, young Kelly was killed. She gave away her organs, her mother gave away the organs. Three families, two from Wisconsin and one from Missouri, were saved, because of Kelly Knockrimer. Her mother came to me and said, can't we do something, Governor, to be able to remember Kelly? And we came up with a program in which every young boy or girl, young man or woman, in Wisconsin, before they get their driver's license, has to have a mandatory 30 minute course on organ donors.

It's not much, but it's the Knockrimer bill, and what a great idea, to convince young people you know that they should talk about it and get involved in it. Those are the kinds of simple steps we can do to reverse this instead of an additional 300 people being added to the list each and every month, let's see if we can't reduce it by 300 each and every month until we solve this problem.

Mr. Young. Mr. Secretary, that's very inspiring. And I think it's a great idea to give the life medal that you just mentioned.

Many of us here have seen the importance of organ donor programs within our own families. But right here in Congress, we have a perfect example. We have a long-time serving member who was near death just a few years ago. In fact, rumors of his death were already on the Floor. He had a double lung transplant and he's alive and well today and he has performed well for this country, especially in the field of national defense.

And I'm talking about Congressman Spence of South Carolina, who served as chairman of the House Armed Services Committee and has made a great contribution. So we've all had an opportunity to see the value of organ transplants.

Mr. Chairman, you have very good attendance today, so I'm not going to use up any more time, because I want to make time for all the other members that are here. Thank you very much.

Mr. Regula. We welcome your observations of the role of this Committee. I think you're the longest serving member that is presently a part of it.

Mr. Young. I think except for Mr. Obey.

Mr. Regula. Right. Was he on ahead of you?

Mr. Young. Yes, he was.

Mr. Hoyer. After 17 years, I feel like a newcomer.

[Laughter.]

Mr. Young. You made up for lost time, Steny. [Laughter.]

Mr. Regula. It is kind of interesting, the Secretary for the Interior Subcommittee of Appropriations just got a lung transplant about two weeks ago. Mr. Hoyer was very helpful with Johns Hopkins in making it happen, and she's getting around now and seems to be doing well. It saved her life, it's just that

simple. She waited a long time.

Secretary Thompson. It's such a moving thing. And I tell people, you know, and I speak all over the country, I tell people, if your organs had a chance to vote on your deathbed, don't you think your eyes would vote to continue to see? Don't you think your heart would vote to continue to beat? And I know your kidneys and livers would continue to vote to enjoy that Wisconsin beer, milk and cheese. [Laughter.]

Mr. Regula. Mr. Obey, our Ranking Member, wants to defer to Mr. Hoyer.

COORDINATED SERVICES

Mr. Hoyer. Thank you, Mr. Obey.

Mr. Secretary, Mr. Istook, who is a member of this Committee, we're holding a hearing now for the Treasury Postal Subcommittee, so I'm going to have to go there right now. But I note in your statement, you say at page 16 of your statement, the only way this Department can effectively serve its many clients is if we commit to making the necessary investments in our management and infrastructure. You go on at the beginning and throughout saying we need to do things new ways. And I share that view.

Then you say later on, that you recognize where you need to invest, but also where resources need to be redeployed to more effective use. Mr. Secretary, I have been talking for many years about the necessity for the Federal Government, including your Department, as well as the Departments of Education, Labor, Transportation, Agriculture, and the other agencies that have programs dedicated to helping children to coordinate better at the Federal level.

These services use the funnel example, we have all these resources and all these departments. And you have the spigot of the funnel where you have the child, that all of us want to help in one way or another. To the extent, Mr. Secretary, you and your colleagues in the Cabinet can come to grips with how better to not only coordinate those resources but to also co-locate those resources, so that those who access those services will be empowered and enabled to do so in a better way.

So I was very excited to hear your thoughts about new ways of doing things, because I think we can do it better. I think we can help States, and you know that as a Governor, and LEAs, local education agencies, and other organizations that ultimately are in the front line of delivering the services that we talk about and fund, but that they deliver. We don't really, for the most part, deliver services. It's States and local governments that do that.

So I would look forward, I have a bill in, or I'm going to have in, the Full Service School Improvement Act, which seeks to enhance the co-location of services from your Department, Head Start being a specific example, and other services as well, in school settings where the only local, as we all know, the only local facility we have in every community in America is an elementary school. No other facility can we name like that. Maybe a firehouse, but few others.

I would look forward to working with you toward that objective and carrying out the premise of your statement, which

says we do good things and we need to do them better, so that we can help people more.

Secretary Thompson. Congressman, that's music to my ears. I don't know how I could do a better job than what you just articulated. It needs to be done.

Mr. Hoyer. I look forward to working with you, Mr. Secretary.

Secretary Thompson. HUD, for instance, you know, has got some programs for the homeless. We've got programs for the homeless, but we never communicate, we never give the services to the proper people. Food stamps, food safety, all of these kind of things that need to have a better coordinated effort. And I'm not here to tell you that I'm the expert, I've only been on the job 80 some days.

But I can see that there seems to be a fracturing of the way the services are delivered. And I would love to be able to work with you and members of this Committee on a bipartisan basis, how we can develop a better coordinated effort. We all want to deliver better services for children. There's no question about it. It's an ultimate objective, and we should have that as an ultimate objective.

But I don't think we're doing as good a job as we can or should.

Mr. Hoyer. I agree with you 100 percent. And we have in a bipartisan way, Mr. Portman and I had a bill in that passed the Congress, signed by the President, which enhances local jurisdictions' ability to come together and make one application for various grants. It makes it much simpler. But we can work on this in a bipartisan basis.

I put \$500,000 in this bill maybe five years ago for study. I worked with them. Unfortunately, they focused on what the locals could do to facilitate and come together. That was good. But what we really need to focus on is how we can make it much simpler for States and local governments, this myriad of programs that are good programs, but are uncoordinated at this point in time between HUD, between Ag and HHS, between Department of Education and Department of Labor, etc.

Mr. Chairman, thank you very much for giving me this time. Mr. Secretary, I'll look forward to working with you on this.

Mr. Regula. Mr. Miller.

Mr. Miller. Good morning, Mr. Secretary. It's a pleasure to have you here for the first time.

Secretary Thompson. Thank you.

STEM CELL RESEARCH

Mr. Miller. Let me agree with the comments by Mr. Young, I'm delighted you're taking on this issue of organ donation. I think the bully pulpit that you have can be very beneficial, and obviously we share it. I'm really delighted on that.

I'm also pleased with your NIH increase. I'm also pleased you're working out at HCFA. It's been one of the most complained about agencies in the Federal Government for many years. I don't think Ms. Scully's been approved yet.

And you also have a man from Florida that's going to be there, too. So I'm glad you're going to get first hand experience.

The first question is, an issue that's come up is stem cell research. I personally support allowing the scientists to make as much decision as they can. I think you've been in that position in Wisconsin. So as a Republican, I encourage you to not tie the hands of scientists as they address that issue. The potential is enormous, as you're well aware. There are of course other sources for stem cells, but we don't know whether umbilical stem cells will do the same that stem cells left over from in vitro that are there. So I don't know where you stand on your decision, but please, hopefully you'll let scientists have the opportunity to find these miracle cures for Parkinson's or Alzheimer's, or all the potential that exists out there. I don't know if you wish to comment on that now.

Secretary Thompson. Thank you very much, Congressman. It's a very contentious issue, and of course, I am passionate about research, as everybody knows on this Committee and in America. There is the legal impediment that's being reviewed, and the legal decisions and the scientific and ethical decisions are being reviewed. Those reviews should be on my desk by the first week in June, and we will be making a decision on that.

CDC BUDGET

Mr. Miller. Good luck on your decision.

A few weeks ago this Committee, a number of us, were in Atlanta to visit the CDC, which is obviously a great organization. I was a little disappointed in the total budget appropriation that you've requested. Could you justify that appropriation? Because it seems like it's on the low side, when the needs are so great there.

Secretary Thompson. Well, CDC just does an excellent job. I've been down there as well, and I'm just amazed at the job they do. A lot of the things that we put into the budget are for increasing the capital physical plants. There are 22 buildings that we're renting in Atlanta, 22 various buildings all over the city. What I'm trying to do is develop a plan in which we can build on our campus. We've got the real estate, but we should be consolidating all of those buildings. It would save money. It would actually save money, if we had the capital buildings built on our land instead of all over, the people dispersed throughout the community, 22. So we put in an additional \$150 million.

I know CDC would have appreciated \$175 million, but I fought very hard to get \$150 million, and it's a giant step forward in order to start another laboratory and another office building on the property that we own. I would hope this Committee would look at it.

In regards to the other dollars, we put a lot of money into NIH. We looked at the total budget, Congressman Miller, and we felt that we could do a better job on contagious diseases and so on if we put the money in NIH. That's where the money went.

Overall, you'd have to give me a specific question as to what you see as an area we didn't deliver on, because I think we did quite well considering the money we had.

NURSE SHORTAGE

Mr. Miller. We'll submit a couple of questions.

Let me ask one more question, there was something you made comment about, that was the nurse shortage problem. A generation ago, nursing and education were the priority for women, and now women have great opportunities everywhere. But there's a real area of retirements coming, both in education and in nursing.

It's very concerning, I know in the State of Florida, the State legislature is trying to upgrade standards in nursing homes and raising the number of nurses, CNAs, but you've got to find them to work. So it's not just the college graduate RNs that are needed, we need CNAs and whether we can get more from overseas, but we hate to take them away from countries that need that type of service, too.

So I'm glad you're putting some emphasis in there. We do have a crisis coming up in the years ahead for the staffing of hospitals and nursing homes and home health agencies, the whole area of caregivers. I think that was addressed the other day in a Senate hearing. But it's going to take a bully pulpit, too, on that one, in addition to the resources.

Make sure you consider the CNA level as much as the RN level, too.

Secretary Thompson. Right now there's a shortage of 250,000 CNAs in this country, and 90,000 RNs. That is a tremendous shortage and it's going to increase unless we do something. It's not only, I can't do it alone. I need your help, Congressman, and this Committee and this Congress, in order for us to try and work together on the nursing shortage.

We have to encourage a lot of young people, men and women, to go into nursing. And it's an important, absolutely important profession that we have to articulate, the satisfaction and the rewards going into nursing.

We also have to find ways in which scholarships and loans would put money into it. But there's always a question whether or not it's enough. We have to look at that as a way to do it. We also have to look at the way the rules and the regulations and the paperwork, a lot of people are telling me that the amount of rules and regulations and paperwork that nurses have to spend their time in filling out takes away from their job of providing health care to the patient. And that's frustrating to them, and a lot of people are leaving.

So there's a lot of problem areas that we have to look at. But there's no simple silver bullet out there. We have to work together on a bipartisan basis. It's going to get worse unless we address it. And I appreciate so much your question. I appreciate also the questions I've received from other Congressmen who want to work on this on a bipartisan basis. This is one area that I think we can all work together on on a bipartisan basis and hopefully solve, or at least address the problem and try and have an improvement as far as the numbers going into nursing.

Mr. Miller. Thank you, Mr. Chairman.

Mr. Regula. Mr. Kennedy.

Mr. Kennedy. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for your leadership on the organ donation. It's a terrific program. We're trying to do more in Rhode Island about that.

I wanted to focus my----
Secretary Thompson. I'm coming up and speak at an organ donor's program in Rhode Island.

MENTAL HEALTH CARE

Mr. Kennedy. Like I said, we're excited about what you're doing. I look forward to having you up in my State.

I wanted to focus your attention today on mental illness. The World Health Organization, World Bank and Harvard University conducted a large study on global burden of disease, and ranked mental illness, depression, depression alone is the single biggest cause of disability. Despite lost productivity to work in this country, despite enormous costs of untreated mental illness, our system imposes additional barriers to treatment.

Medicare, for example, requires a 50 percent co-pay for outpatient mental health, but only 20 percent for other diseases. And it caps hospital stays for mental illness, but not for other diseases.

The implication of this differential coverage is that mental health care is not real health care, that mental illness is somewhere between elective surgery and real health care. Mr. Secretary, given all these studies, the Surgeon General's report on children's mental health, the National Academy of Sciences that says that it's unsupported that there's any physical health difference in science between mental health and overall health, will you support parity for mental health insurance coverage in this Nation in Medicare?

Secretary Thompson. I did as Governor. In fact, I was maybe not as passionate as you, Mr. Kennedy, in your remarks right there. But I certainly feel as strongly as you do about it. It needs to be done. But it's not going to be overnight, I've got to tell you that.

Mr. Kennedy. I understand that.

Secretary Thompson. There's been a long period in which there has been a degree of discrimination for mental health versus other overall health, as you've indicated.

Mr. Kennedy. Absolutely.

Secretary Thompson. There have been a lot of rules and regulations, and every time you change it, you know, there's a fiscal impact. I can tell you this much, I think it needs to be done, I think we should work in that regard, and I would like to work with you on that.

But I want to tell you, it's not going to happen as quickly as you would like or I would like.

Mr. Kennedy. I agree. Your leadership, though, like with the organs, speaking out on this issue, would be very instrumental. Because again, this is a matter of stigmas, which is one of the biggest barriers. Talking about it like you do organ donation, in terms of your audiences, would be a big, big help. I encourage you do to that whenever you have a chance.

Secretary Thompson. Thank you.

Mr. Kennedy. With regard to that, we have found that the Community Mental Health Services block grant, has been a very effective tool in implementing the President's idea of the Olmsstead decision, with its New Freedoms Initiative. Try to get

some community based support services. And in my State of Rhode Island, institutionalization of children with serious mental illness is a default option. The chief of adolescent and child services at Bradley Hospital, one of the nation's leading in psychiatric hospitals, says half of their children any given night could be in less intensive community based settings.

What we need to do is, and all the experts are telling me this, we need to support additional money for the Community Mental Health Services block grant. Unfortunately, this budget freezes the Community Mental Health Services block grant, and I would encourage you to review that. Because it goes to what you're asking for, more implementation in the community and less bureaucratic setting. This is all about what I think your leadership has already demonstrated about getting it into the community.

Finally, in respect to two areas of mental health coverage, one for children, obviously we could do a lot better in Part C of IDEA, which is not in your Department, but goes to Mr. Hoyer's whole issue of trying to get some coordination between all the different departments when it comes to children's issues. That could be increased.

But the point I wanted to make is, if we could get early interventions with children in the schools, we'll save ourselves so much money on Special Ed, so much money on other programs that probably kick into the Justice Department and into other services. It's definitely our charge to reach out into the schools.

Secretary Thompson. Can I Just interrupt real quickly?

Mr. Kennedy. You bet.

PRACTICE HEALTH

Secretary Thompson. I really think this Committee and my Department that I head needs to look at preventive health overall. I really don't think we have done enough in America. And you, as the policy makers, to look at ways in which we invest our money up front, to wait until people get really sick, and then we put the money in there. It costs more, and we should be doing things in mental health and children and so forth up front. It would be an investment that I would like to see us look at.

I know it can't be done overnight, but I think that's the direction you would like to go. I know it's the direction I'm trying to lead the Department.

Mr. Kennedy. Well, you know, with CDC, which we did get a chance to go down and see, the biggest health problems in the future are all behavioral, obesity, smoking continues to be a problem, diabetes, managing asthma, which you put an increase in, all has to do with behavioral and managerial science. So your emphasis on mental health not being something of a stigma, but focusing on total health, would be incredibly important.

I like the idea of incenting. And HCFA, now that you're up at HCFA, if we could just get HCFA to incent reimbursement for outpatient and preventive services. I don't know how you do it with the insurance industry now looking at the bottom line every quarter. Once you have a public offered company, you're in trouble when it comes to an insurance company, because they

need the bottom line rather than the long term health consequences of investing early and prevention, rather than just taking care of people when they get sick.

So your leadership in HCFA to try to reverse this reimbursement mechanism to provide incentives for prevention would be extraordinary. Mr. Chairman, finally----

[Laughter.]

Mr. Kennedy [continuing]. Senior mental health; those 85 and over, are six times more likely to commit suicide. We have a baby boom generation ready to retire. We have no infrastructure in place to deal with identifying depression among seniors. Over-utilization under Medicare is one of the biggest problems we have in terms of a budget consideration going forward. And you mentioned Medicare coming in.

We could cut that down if we had properly diagnosed depression. I can tell you more anecdotal instances where seniors come to me and tell me about how they went to every last doctor, the podiatrist, the heart doctor, this doctor, that doctor, we know we're all getting the bill, why can't we address their fundamental problem, which is a mental health problem? Our doctors are not trained to identify mental health problems. All I would do is encourage you to try to help our medical schools try to get more mental health training, so they can more properly diagnose depression early on, rather than leave it untreated.

Secretary Thompson. I want to work with you, that's all I can tell you, so you come up with your ideas, and let's sit down and discuss it at greater length with you in your office or mine.

Mr. Kennedy. Me too.

Secretary Thompson. I've told the people at HCFA, I addressed all the employees, you'll appreciate this, I said, you know, you spend a lot of time up here trying to find a way to say no. I would like to see a behavioral change and try to find a way to say yes.

Mr. Kennedy. All right, thank you, Mr. Chairman.

Mr. Regula. Good for you, that's right. Mr. Wicker.

Mr. Wicker. Thank you, Mr. Chairman.

First, I want to yield some of my time to Mr. Kennedy on the issue of prevention, but I see I don't need to. He took it.
[Laughter.]

OBESITY AND DIABETES

Mr. Wicker. And I'll get back to that in a minute.

It is wonderful to have you here. I think you can see from the questions on both sides of the aisle that there's a great deal of enthusiasm for the type of leadership we believe you'll bring to this very difficult department.

Chairman Young mentioned Amtrak. Frankly, I admire your ability to think outside the box and think for yourself and not take an old answer for granted, and I expect you to do the same thing as Secretary.

Also, Mr. Chairman, you mentioned the two greatest commandments, love God and love your neighbor. The Secretary echoed that in his initial remarks. It happens that my wife and I teach fourth grade Sunday School at First Baptist Church in

Tupelo. We taught that very lesson this past Sunday.

The only thing I would add is that what the Scripture says is that the first commandment is love God, and the second commandment is like unto it, love your neighbor. In other words, the two commandments are almost the same. When we take care of our neighbors, as your department does so well, we are fulfilling that first commandment, too.

Back to what Mr. Kennedy said about prevention. I couldn't agree more with what you and he have both concluded. It does concern me, therefore, that the budget proposes to cut chronic disease and prevention, health promotion, by some \$22 million. We also had \$152 million for a one time program, so that actually amounts to a \$175 million cut. I think we really need to re-look at that, Mr. Secretary. Because what has been said already is correct.

The research is part of it. And NIH, I support every penny of research that you want to put into NIH. But they are telling us solutions that we then need to apply. And as Mr. Kennedy says, we already know what the great killers are. The greatest causes of disease and disability are heart disease and stroke, cancer, diabetes and arthritis. And we know right now how to prevent these.

So I would hate to think that now that we've got some programs, State based programs, to prevent these diseases, such as diabetes, cardiovascular disease, this huge epidemic of obesity and particularly childhood obesity, and we're about to go nationwide with those, I would just hope that the Administration could either explain its rationale about cutting appropriations for disease prevention, or perhaps better yet, get with the Committee, get with the Subcommittee, and rework the numbers, so that we can continue to do the research, but also the prevention on things we already know how to address.

Secretary Thompson. I appreciate your question. Let me try and answer it this way. We have to do something about obesity and diabetes in this country. It's going to be growing by epidemic proportions in the coming years. What we have to do is we have to change the quality of life issues. People at CDC tell me that 75 to 80 percent of the diabetes in America and the conditions affected in diabetics, could be alleviated by eating properly and exercising properly.

Now, we've done a fairly good job of reducing smoking in America. We should redouble our efforts to inform people about eating properly and about exercising properly. The Administration feels very strongly that we are close to coming up with some breakthroughs on some of these chronic diseases. That's why we've put the money, we put in an additional \$629 million in research up at NIH for these diseases.

Granted, there's a \$23 million reduction in CDC. But when you compare that with a \$629 million increase at NIH, we think that's a better bang for the buck.

Now, it's in your power, you know, to change that. But we think that NIH and research, in order to find that, is something that needs to be done. That's why we made that decision, Congressman.

The second thing is, in regard to asthma, we put in a lot of additional money up there. Because we're looking for some medical reasons to reduce asthma. Asthma happens to be the

number one cause, especially for poor children in urban settings, as to health reasons, to skip school. What we need to do is find a way to prevent that or reduce it. That's what we're trying to do through NIH. That was the decision that was made.

Mr. Wicker. Okay, I want to listen further to you on that, on the contention that further research at NIH on diseases such as cardiovascular and diabetes gets it out to the consumer. I will just add, and I will not ask a question, that the CDC testimony has always been that the State based cardiovascular disease program is a good program, it's working and it's ready to go nationwide. And so I just look forward to visiting with you further on that.

Secretary Thompson. I appreciate that, Congressman, and I'm very accessible, as people will tell you, be more than happy to sit down and discuss it at greater length with you.

Mr. Regula. Mr. Obey.

DEPARTMENTAL BUDGET

Mr. Obey. Thank you, Mr. Chairman.

Governor, Mr. Secretary, it's good to see you. Sorry I was late, but I had a few other things I had to deal with this morning.

Before I ask a few specific questions, I would simply like to make a general observation about the Administration's budget for your Department. And I know that you tried as much as you could in order to get the best number that you could for the agency. The budget does have an increase of 14 percent for NIH. Frankly, both parties have been stumbling, running to the nearest microphone for the past two years, each trying to out-do the other one in terms of support for NIH. And that's going to continue. It's become a holy picture item in this budget.

I'm all for seeing those increase. The problem is that when those increases in research occur, we get more knowledge that very often will also create more expensive options for people who now have hope where there was none before. And yet, given the shape and nature of our health care system, we often can't deliver the goods in terms of the results of that research to the poorest people in this society. And we have a devil of a time disseminating the information, especially to rural areas, that are really underserved medically in many, many ways.

I think this budget in that sense exacerbates that problem. Because if we gave NIH the 14 percent increase that they're asking for, and increased nothing else at HHS, the result would be about a 6 percent increase in the Department's total appropriation. But that was too large to fit into the Administration's budget plan, so they made a wide ranging series of cuts. There are very few programs that receive the 4 percent increase that has been talked about in the press. And there are a number of programs that received actual cuts below current year's level.

The administration's basic budget is a \$2.8 billion increase for NIH and essentially a \$200 million cut when you look at the ups and down for other remaining programs. If you look at some specifics, in terms of what was delivered this year versus what will be delivered next year, the Low Income

Heating Assistance Program will be about \$500 million short of the actual money that was delivered for this year.

HRSA, the agency most involved in trying to get basic health care to rural areas and inner cities, and to uninsured people, will receive a 10 percent cut below the current level. Adjusted for inflation that's more like a 13 percent cut. For CDC, some of those cuts have already been mentioned by people on both sides of the aisle. Head Start receives a 2 percent increase, which is not enough to even cover the mandatory cost of living adjustments and will lead to a reduction in the quality of that program, in my view.

And so I am concerned about the fact that we're going to have some very large tax cuts for some very wealthy people. But it's like our friend Harvey Dueholm used to say in the legislature, the poor and the rich get the same amount of ice, but the poor get theirs in the winter time. I'm not very enthralled by that result.

But having stated that, I'd like to ask a couple of specific questions about provisions of your budget. And they go to the issue of States being given more flexibility in using health grants.

Let me ask you to clarify a point, where I think the proposed legislative language is ambiguous. You allow 20 percent to be moved around. Is that 20 percent limit to be applied grant by grant or only to the aggregate of all grants that a State receives?

Secretary Thompson. It's supposed to be only the aggregate, Congressman.

Mr. Obey. Only the aggregate? All right. So will this apply to grants that are awarded on a competitive basis, rather than under a formula?

Secretary Thompson. It's supposed to. But I'm not exactly sure on that, Congressman.

Mr. Obey. If there's somebody here who could tell us that, or if somebody----

Secretary Thompson. Yes.

Mr. Obey. So the answer is, it would apply, the flexibility will apply to grants that are awarded on a competitive basis, rather than formula?

Secretary Thompson. That is correct.

Mr. Obey. Let's suppose the State wins a grant based on the strength of its application. Would the State then be allowed to use part of the grant funds for something completely different from what was described in its application?

Secretary Thompson. It's our understanding that that would be put through the rules, and they would not be able to do that. They would have to be in the basic overall rubric of what the grant was for.

Mr. Obey. Well, I've got a number of other specific questions for the record, so that we can understand the details.

Secretary Thompson. Why don't you submit them and we will answer them for you, Congressman.

Mr. Obey. I'd appreciate your responding to that.

Secretary Thompson. I'd be more than happy to.

Mr. Obey. Then with respect to community health centers, I note that the President's announcement made a lot of the fact that you were providing for an increase over last year. But as I look at the numbers, the increase that's provided this year is actually smaller than the increase that was provided last year for that same program, isn't that the case?

Secretary Thompson. That is correct. It still is a huge increase, Congressman, overall. We're trying to almost double the number of underserved and the uninsured patients that's going to be covered from 11 million. Our goal is to get it up to 20 million.

STEM CELL RESEARCH

Mr. Obey. I know what the goal is. My problem is, I don't think the recommendations are going to do enough to help get us to that goal. Because first of all, it's a smaller increase than we provided last year, which is, I think, a quaint way to reach a goal, by slowing down. And secondly, I think that it's financed by taking virtually the same amount of money out of efforts to coordinate those services in a number of communities, including an area like Milwaukee, which got a \$900,000 grant under the program that's being cut back, in order to help finance this \$150 million increase. And I don't see much gain there.

I would also simply make one additional point, because I don't want to take more time than is necessary. This issue of stem cell research. I envy the certitude with which people on both sides of that question plunge ahead and attack people who disagree with them. But I remember Eric Sevareid said once, that one of the requirements for a civilized citizenry was that we hang onto our informed doubts in a world of passionate certainties. And I think in this area, I frankly don't know what the right place is to cut the line with respect to stem cell research.

There are incredible equities on both sides. And I simply hope that you are allowed to make that decision on the basis of merit, rather than on the basis of political or ideological pressure from either side on the issue, because these are fundamental questions of both ethics and mercy. And I would hope that rather than screaming at each other on issues like this, we would be trying to work with each other, to work through some very troubling, conflicting sets of values on one of the most complicated issues that faces any policy maker in this country. I wish you well in deciding what you're going to do about it.

And with that, Mr. Chairman, let me save my other questions for later.

Mr. Regula. Would you like to respond?

Secretary Thompson. I'd just like to first thank the Congressman for his advice and his suggestions, and tell you that we're looking very diligently at the stem cell matter, and it's not easy.

Mr. Regula. No, it's not easy.

Mr. Sherwood.

Mr. Sherwood. Thank you very much, Mr. Secretary. It's good

to see you again.

Secretary Thompson. Thank you very much, Congressman.

MEDICARE

Mr. Sherwood. I commend you on your commitment to reform and redirect HCFA. Representing rural northeastern Pennsylvania, that's music to our ears. You really have your work cut out for you.

One of the great inequities in this country, I think, people in rural Pennsylvania or other parts of the country have all paid the same Medicare taxes over their working lives. But because of the way that HMO Plus Choice was funded, seniors in some parts of the country do not have that option any more. I would like your thoughts on that, and what we could do to correct it.

I worked very hard in the last Congress to get enough money put in the bill so that we wouldn't lose our HMO Plus Choice providers, but money moved out anyway. And it was particularly distressing to me to find out later that the changes that were made allowed premium reductions in some areas. Because we have an old system here that started from a very low base and increased it over 20 years by percentages. I think you'll find some areas of the country that are very well funded and ours just doesn't work.

Secretary Thompson. You've raised several questions, and let me try and hit them one at a time. First off, as far as HCFA's concerned, there's a lot of great people out there, a lot of dedicated people who want to do the right thing. First off, we have a bookkeeping system out there that is really arcane. And there's money in here, \$36 million, to change that.

We're still using a single entry bookkeeping, and we're running the largest health insurance company in the world. Absolutely unheard of. We have some 30-year-old software that has all of the data for all the Medicare patients in America, that the processors, the fiscal intermediaries and the carriers use our software, the 30 year old software, in order to make out the payments.

To me, it's an accident waiting to happen. We have to change that.

We also I think should change the name of HCFA. I mean, it's very difficult for people to get very excited about a HCFA. It's a Medicare and Medicaid association, and that's what it should be called. And the acronym would be MAMA, and that would be something that people would learn to love. [Laughter.]

And it would be something that I think we should consider.

In regards to Medicare plus choice, something I'm very interested in. I don't think it's been given the right amount of attention over the last several years. And I'm not being critical at all, I just think it's such a huge agency, you have to look at the things that you can, you've got a passion for, and the things that you can do. I think Medicare plus choice, I think this Congress last year and over the course, through BPA, over the course of the next four years, is putting an additional \$4.3 billion into rural areas across America.

That money hopefully is going to, some of that's going to be in Medicare plus choice. We have to find ways in which we

can encourage more Medicare plus choice. At one time in the last couple of years, there were 16.6 percent of the Medicare recipients that had Medicare plus choice. It's now down to around 15 percent. When Medicare plus choice was passed and the Balanced Budget Act of 1997, the projections were it would be up to 30 percent. There has to be a way for us to address this, look at it and find out why people are pulling out of your area and other areas, when your beneficiaries and constituents in your area are asking for it.

We're going to be looking at that. We're going to make a detailed study of it. I would like to work with you and try and find some ways in which we might be able to encourage more, especially the ones that are in it, not to pull back any more.

Mr. Sherwood. Thank you very much. But I think we'll find that the reason they pull out of certain areas is that the funding in those areas is much less than the ones they stay.

Secretary Thompson. That's very true.

Mr. Sherwood. We have equal citizens, but we don't do equal funding. That's one of the great inequities that's been disappointed to me since I've been here.

Secretary Thompson. Mr. Sherwood, Congressman, you know that when you have any type of a formula fight, they become the most vicious and most controversial of any fights at all, because it affects money going into your district. And it's not a partisan one. It's a bipartisan one.

So you're going to have to find ways in which we're going to have to equalize the system, but you're not going to be able to take money from the higher priced areas to equalize it, I don't believe, if you're going to be successful.

Mr. Sherwood. Well, we've got to find an answer. Thank you.

Secretary Thompson. I appreciate it. I know the problem you raise, because I dealt with it as Governor of the State of Wisconsin. I always thought it was crazy that Wisconsin was being penalized, and now I'm finding out it's a much more complex subject. And I find out that you're hurting in Pennsylvania as we were in Wisconsin.

Mr. Regula. Mrs. Northup.

LONG TERM CARE INSURANCE

Mrs. Northup. Thank you. Welcome, we're delighted to be looking at the challenges we face to see if we can improve the programs we have or change the ones that may need some fine tuning.

I have two areas I'd like to ask you a couple of questions. First of all, long term care insurance. It is my observation that both Medicare and Medicaid are under a great deal of financial stress. This is increased by the number of senior Americans that need to see either Medicare services expanded, or Medicaid expand the number of people they are able to care for. Because they have nothing else to rely on for long term care.

I believe we're going to need a new revenue stream to address long term care issues. When we do that, we will relieve some of the financial stresses on Medicare and Medicaid, so that they can better meet the needs that they were originally created to address.

I believe that is your long term care insurance, private insurance. And yet many Americans today have no access to such insurance. They are unaware or unfamiliar with the need to get it, and get it at an early age. We aren't creating a growing population with a private stream of money that can address these needs, so that the pressure will be taken off these other programs.

Do you have any observations or thoughts about what the Administration might do over the next couple of years to grow long term care insurance?

Secretary Thompson. It's needed. You've addressed one of the big problems. I think there's two huge failings in public health in America today. Number one is that we don't do enough of preventive health. And we waste too much money waiting until people become acutely sick and end up in a hospital, then we start paying. I think that's problem number one.

I think the second problem is, we haven't had enough leadership or enough support to develop a long term care insurance program in America.

Mrs. Northup. I would like to work with you on that. I'm eager to do that.

Secretary Thompson. Mrs. Northup, that is something that needs to be done if we're going to really help Medicare and Medicaid.

TOBACCO PRODUCT RESEARCH

Mrs. Northup. Let me address, from a little bit of a different point of view, the prevention aside of healthcare. NICHD or one of the NIH institutes was here recently, and just sort of dropped in to the course of their testimony that all the money we've spent to discourage teens from using tobacco products, what we've found is that while there may be an immediate positive effect, several years after they're out of their teens, the difference in the number of young people that use tobacco products that had the programs compared to those that didn't have the programs is negligible.

I feel like that is reflective of a lot of our efforts at changing behavior. We only have to look to ourselves to understand that. Every one of us understands eating properly, not using tobacco products, getting regular exercise, I could go on and on how important it is. We have good weeks, we have bad weeks. Some of us really struggle with all these health habits, including eating good, healthy, nutritious meals.

And so as I nag my six children, I'm not surprised they don't all wake up the next morning and have yogurt for breakfast. I think that there's not enough research on what works. Instead, we have an outcry for spending more. I'm eager to see us, before we spend more money on prevention and so forth, to make sure that we have better controls in place about what works, who's doing the research, whether it's legitimate research, and that we have some long term input, so we don't keep pouring money into programs that we find out later someone has already assessed and found out it didn't make any difference.

Secretary Thompson. All I can say is, long term health insurance and changing people's habits is important. I don't

know if you need more research, when we all know what the problem is. We eat too much, we don't exercise, we smoke too much and we drink too much.

Mrs. Northup. Except that we're spending a lot of money on discouraging kids from using tobacco products, something that I have been a strong advocate for. Now we find out that despite the fact that we have increased money for these programs, when they compare the populations that took part in these programs with the populations that didn't there's basically no difference between them.

So we need another approach. We need to at least open our minds to a different paradigm. And I feel like a lot of times what Government does is keep pouring more money into programs without assessing whether the long term goal is achieved or not.

Secretary Thompson. I couldn't agree with you more. But I'm not sure of the study you're talking about. I'm not privy to it. I do know this much, that the Surgeon General and myself unveiled the causal relation of smoking and women's health, especially lung cancer, which is the number one killer of women.

Mrs. Northup. Huge. Huge.

Secretary Thompson. It's overtaken breast cancer. And we found that in teenagers, if you don't smoke while you're a teenager, 85 percent of those individuals when they reach 21 will not smoke. So it's important for us to get to the teenagers if we're going to prevent smoking.

We also found out that 30 percent of the high school students this past month had a cigarette, smoked. So we know those facts and figures. I don't know what further study is going to do, except get the information out that smoking is harmful to your health, you shouldn't smoke.

Mrs. Northup. Well, I couldn't agree with you more that you shouldn't smoke, that we ought to try to discourage kids from smoking and that the effects of smoking are devastating to health. I'm just hopeful that besides spending to address the problem, we might ought to spend money to assess whether or not the programs we're funding actually are achieving a long term goal.

Secretary Thompson. We have been effective in reducing smoking in America. We've gone from 52 percent of the population down to 26 percent of males and 23 percent for women. We've dropped from 32 percent of women smoking down to 23 percent. There's been a much bigger percentage of drop between males than females in our society. We know that.

I think we have to, as a country, rededicate ourselves to making the same kind of concerted effort, eating properly and exercising properly. We have to renew that, and it has to be constant. I'm not smart enough to tell you what program or what buttons to push to accomplish that. I just know that 75 to 80 percent of the diabetes, which has an impact of about 22 percent of our Medicare dollars, is caused by diabetes, that 75 to 80 percent of the diabetic conditions can be altered or stopped by eating properly and exercising properly.

To me it's a tremendous causal relationship that we should work on to get that information out and try and encourage people, like we encouraged people to stop smoking, to eat

properly and exercise.

Mr. Regula. Mrs. Granger.

Mrs. Granger. Mr. Secretary, thank you for being here, and thank you for taking the job. It's important.

Secretary Thompson. Thank you.

Mrs. Granger. Several things. First of all, I want to compliment you on your hands-on approach to HCFA. I really learned what was happening to physicians and their offices when one of the physicians in my district said, come spend a day in my office. So it really does make a difference.

Secretary Thompson. No Secretary has ever done this.

PROMISING PRACTICE PROGRAM

Mrs. Granger. It's wonderful. Very good.

And also, on prevention, I agree with everything you said. One thing, if you're not familiar with it, promising practices program, headed by Dr. Jean Spaulding at Duke University Medical Center. It's excellent. She went after diabetes, asthma and hypertension and heart disease. Very cost effective, very practical, done some really, really good work in prevention that I would certainly recommend.

Secretary Thompson. These programs work. We've got to get the information out.

Mrs. Granger. That's right.

Secretary Thompson. There are great examples, what you've just said, all over America that show how we can live much healthier, more productive lives.

Mrs. Granger. Yes. This took it to the community and really could be replicated almost anywhere, very good. I want to talk just a second about substance abuse, and tell you how pleased I am at your increase on that. Again, I've been working with Duke on some treatment and what they're discovering about addiction, which is really fascinating. If we're going to put all this money into stopping the supply, if we don't do something about the demand, we're the ones that are using it.

But one thing that's very important, what they're discovering about addiction is, it doesn't take 30 days in-patient for drug treatment. It can be done very, very differently and much more effectively. So I think that's very, very important. I think it's important that we fund to find out what works, and then really work with that drug treatment that works. It's going to be very, very important to us. The drain on our families and the drain on our health care system from substance abuse is still enormous.

Secretary Thompson. It is. I appreciate your concern on that.

Mrs. Granger. Love to work with you on it.

Secretary Thompson. I'd love to work with you. Do you have suggestions that you want me to come over and talk to you about?

Mrs. Granger. I'd love for you to, thank you.

Secretary Thompson. I'd appreciate it.

Mrs. Granger. Good, thanks.

Secretary Thompson. I love ideas.

Mrs. Granger. I collect them.

Secretary Thompson. So do I. I try to implement most of

them, but it's impossible.

Mr. Regula. Mrs. Lowey, can you get done quickly?

Mrs. Lowey. I'm going to be very quick, because after so many people have spoken on the issues that I care passionately about, I just want to say I agree, and I'm very enthusiastic about working with you.

Congressman Kennedy talked about mental health parity, and I just want to add to that, you said it's going to take a long time, some of us have been working on this a very long time.

Secretary Thompson. I know you have.

COMPREHENSIVE SCHOOL REFORM

Mrs. Lowey. Hopefully with your Administration we can get it done.

Secondly, I wanted to add a couple of words about Congressman Hoyer's comprehensive school program. We've been working on that for years, seeing some great results in Port Chester, New York, and I know Congressman Hoyer has other examples of success. We can really see all the services in that school, including adult literacy programs, kids are staying after school, and I wholeheartedly support you on that.

I also wanted to make a couple of points, because we've been talking about prevention on this Committee for a very, very long time. I happen to agree with you, it's been shown that it works. When you look at all the diseases, I don't even have to go through the list, because I know the Chairman wants us to hurry, prevention is absolutely vital.

I do hope that although we've had great increases in the NIH, that we can work together as Congresswoman Northup said to fine tune parts of the budget, including the CDC. I feel if you can't translate all this research into great programs that affect people, we're not doing our job.

And specifically, the budget proposes severe cuts in the CDC program for chronic disease funding, including termination of a media campaign designed to teach children the importance of regular exercise and good diet. Well, that to me is madness. If one commercial isn't working, we have to try something else. I agree with you that prevention is shown to work. And I look forward to working with you to fine tune the prevention part of that budget, specifically funding for CDC, so we can do more about obesity, smoking, all these addictions that many of us may be subject to.

If we can get these kids early and fund the CDC to continue doing this good job, I think we'll make tremendous progress. And I thank you so much for your testimony. I look forward to working with you and the Chairman in fine tuning the budget a little bit in different areas.

Secretary Thompson. Thank you.

Mrs. Lowey. So I'll stop. I have other things to say about child care and we'll have to do it at another time. Thank you very much.

Secretary Thompson. Thank you, Congresswoman. I appreciate that.

Mr. Regula. We're going to recess. We have the rule on H.R. 10, and then we have a journal vote. We'll be back as quickly as possible.

My list when we return is Mr. Peterson, then Mr. Cunningham, Ms. Pelosi, Ms. DeLauro and Mr. Jackson. We'll stand in recess.

[Recess.]

Mr. Regula. Okay, we'll get started. I think Mr. Cunningham, by virtue of being here, you're up. [Laughter.]

Mr. Cunningham. When you're hot, you're hot. When you're not, you're last, Mr. Regula. Thank you.

Hi, Mr. Secretary.

Secretary Thompson. Hi, Mr. Cunningham.

OFFICE OF WOMEN'S HEALTH

Mr. Cunningham. I want to bring to effect, not many people remember, but you and Governor Engler, with your leadership, spent hours on welfare reform with our task force and stuff like that. You see what a benefit that is. I think you're going to do the same thing with HCFA.

My father-in-law had me spend a day in the office with his doctor, and it was a nightmare, not just for the receptionist and the administrator, but for the doctor as well, and the amount of time.

I have another issue, a little different, I'm not going to repeat some of the same questions. The Office of Women's Health has been an administrative position. We'd like to make it permanent. We're also starting on a very bipartisan---

Secretary Thompson. I did not know that, that it was not permanent.

OFFICE OF MEN'S HEALTH

Mr. Cunningham. Yes, it's an administrative switch instead of legislative. We'd like to make that permanent. And by the same token, it's been so beneficial in getting information out and collating different responses, we'd like to start an Office of Mens Health. It's supported on both sides of the aisle, it's supported by the women. And a lot of the work is very similar. Matter of fact, when you talk about prevention, that I think can really help.

We also have, I'd like to invite you, with Mayor Williams, with Dr. Klausner, a cancer research town hall meeting for prostate cancer within D.C. The highest incidence, I'm working with Mike Millken, the highest incidence of prostate cancer is for the African American community. Of all the areas, Washington, D.C. is the highest. And they've never had a town hall meeting for those folks---

Secretary Thompson. I did not know that.

Mr. Cunningham [continuing]. Right here in our capital that have that. We'll send you a time on it.

Secretary Thompson. That's awfully nice of you to be doing this.

Mr. Cunningham. No, I'm on the D.C. committee. [Laughter.]

STEM CELL RESEARCH

Trying to make some small victories there.

The only thing we really deal with with pro-life and pro-

choice that you're aware of is the funding for or against. And in that area, I'm pro-life in my own personal beliefs.

But I want you to know that I have spent a lot of time out at NIH at the training universities and the teaching universities and the biotechs. And I'd like to let you know, as a pro-life supporter of stem cell research, when you're talking about diabetes, you can take pancreatic cells and inject into a juvenile diabetic where they don't have to get the finger sticks, with the different burn and cancer victims, it's amazing what that research is doing.

I'd like to echo the same response that many of my colleagues on both sides of the aisle have put forth, is that members on both sides of this issue are supportive of stem cell research. It's difficult, the toty and pluripotent cells. But those are going to be thrown away anyway from people that discard those and why can't we use those for not only saving life but the quality of life as well?

I want you to know there's people on both sides of the issue that are supportive of that.

Secretary Thompson. I know that, Congressman, but there still is the law that is there.

Mr. Cunningham. Oh, I know, Tommy. And it's something, though, I think we need to work toward on the research of both of that, the areas.

I don't really have any more, I was going to cover HCFA, I was going to cover prevention, and my colleagues have done that. But I'm not going to go through and just reiterate the same questions.

But with the remaining time, is there anything that you would like, that I have remaining time, that you would like to say that you haven't had a chance to say?

HEALTH CARE FINANCING ADMINISTRATION

Secretary Thompson. I'd like to say this, that I'm very much a people person, and I love the opportunity to work with you on a bipartisan basis, with all of the members on this Committee. I really would like to continue the dialogue and be able to take an issue, whether it be the reformation of HCFA or whether the NIH funding or CDC funding and have a committee meeting specifically on one thing, and how we might be able to work together on a bipartisan basis to reform HCFA.

I've got lots of ideas. I'd like to bring in my HCFA director. But I've got many ideas myself, and I'd like to put them out here in front of the Committee. And maybe anybody that wants to come, sit down and say, these are the things that I would like to do at HCFA, and I'd like to have your support. Some of these things we can do administratively, but others, we're going to have to have some kind of legislation, such as contracting.

It's going to be contentious and controversial. But it makes no sense to me, Congressman Cunningham, that a contracting procedure for HCFA that was set up in 1965 should still be the way that we put out contracts in the fiscal intermediaries and the carriers.

DEPARTMENTAL REGULATIONS

Mr. Cunningham. I was thinking even more recent, the departure of President Clinton, they at the last minute put a whole bunch of regulations that are burdensome, costly, tie the hands of HCFA, and those kinds of things I hope would also be covered in this.

But I want to thank you.

Secretary Thompson. I don't know how we would interact doing that, if I could come to you and say----

Mr. Cunningham. Oh, you come to the Chairman. [Laughter.]

Secretary Thompson. I'll come to the Chairman and see if we could have a short Committee meeting.

Mr. Cunningham. Yes, sir, like we did on welfare reform.

Secretary Thompson. People want to do these types of things. But in a setting like this, where there's the whole budget it's pretty hard to get into real specific details of what we want to do on a particular subject.

Mr. Cunningham. Thank you, Mr. Secretary.

Mr. Regula. Mr. Secretary, I've already made a note, I'm a great fan of oversight. There's not enough of that in the Federal government.

Secretary Thompson. I agree with you.

Mr. Regula. What I anticipate doing is, once we get a bill out and we have a little time, perhaps in July, we will do just what you were discussing with Mr. Cunningham. We'll have a hearing or two and focus on one of these areas in an oversight way. We'll welcome your suggestion as to what you would like to do, based on your experience down there.

My staff just wrote a note, we have a HCFA hearing scheduled on May 9th. I don't know if you want to participate in that one or not.

Secretary Thompson. Why not.

Mr. Regula. It would be your call. I think what I hear you saying is, let's find out what works, be pragmatic about this whole thing.

Secretary Thompson. Absolutely.

Mr. Regula. Mr. Peterson.

Mr. Peterson. I'd just like to suggest, when you talked about having a working session with the Committee, maybe a dinner meeting some evening. We are not interrupted. Around here, it's tough, with all the pressures. But if you can get everybody isolated for 7:00 o'clock or something in the evening and have a couple hours of working session, that's just an idea. That would be up to the Chairman's call.

Mr. Secretary, I'm excited about your leadership in this huge agency. I just hope you don't lose your energy level. I've seen these departments wear people down at the State and the national level, because there's just so many components that you have to deal with and they're so big. But I think we're blessed to have someone with your leadership skills at the State level and someone who has the record that you have of a can-do, get things done, working bipartisanly. There was a great consternation a while ago here from one of the members about some small cuts that you inflicted.

I've seen good Cabinet people like yourself take huge agencies and energize them where more happened with less, actually more. I think here we don't talk about that very much. But I've worked with four governors, and I've seen governors at

the State level energize departments and absolutely improved outcomes with not more money, but energizing a huge bureaucracy to be more effective and efficient.

So I'm looking forward to this kind of leadership from you.

Secretary Thompson. I can tell you this much, Congressman, the people at HCFA have just received me with open arms. They could not believe that a Secretary, a person would come visit them so I could spend a week with them. They really want to change. They want to do things differently.

Mr. Peterson. I'm sure they're as tired of being picked on as we are of picking on them.

Secretary Thompson. I think so, yes.

RURAL HEALTH CARE

Mr. Peterson. I just want to quickly go back. I'm told by my State people that your record in rural health care is excellent. I represent a huge rural district. My number one issue is rural health care. Because the system has been slowly phasing it out, that's the term I use, and when rural hospitals fail and rural agencies fail, they go to the urban areas where we pay a lot more for the same care, treating the same people and they're not close to home.

So if I were a HCFA manager, looking for economic use of my dollars, I would be treating people where it's cost effective, and there's no doubt about it, it costs less money to treat people in the rural setting than it does in the urban setting. But we've had a system that's been rewarding urban care and penalizing rural care for a long time. It may be as much Congress' fault as HCFA's. But it's one that I hope you can make HCFA more rural friendly, or understand the complexities of their rules and how it impacts on rural hospitals and rural health care agencies.

Secretary Thompson. I come from a community of 1,500 population. We don't have any stop and go lights. I tell people, you can call someone, get a wrong number and still talk for half an hour. That's how small my hometown is.

Mr. Peterson. I come from 986.

Secretary Thompson. Well, you and I know what the small, rural communities are all about then.

LONG TERM CARE INSURANCE

Mr. Peterson. My largest community nearby is 5,500. That's where our hospital is. And they give very good, quality care.

Long term care was mentioned by the member from Kentucky. I have a bill that would remove the Waxman language that prevents States from getting waivers. Now, I'm not so sure we should even have them get waivers. But we have language that prevents States from getting waivers to offer people credit for long term care insurance. So if they would have \$300,000 of long term care insurance, they could shield that much of their resources, they wouldn't have to spend it. But they provided for it.

And to have a law that prohibits that just makes no sense. Because it's prohibiting the sale and promotion of long term care insurance where people take care of themselves.

Secretary Thompson. You need to encourage more people to get long term----

Mr. Peterson. Yes, I would hope you can help us. Our bill just removes the Waxman language that prohibits waivers. In my view, I don't see why you should have to have States have waivers, why that shouldn't just be allowed. So I'd be glad to work with you on that if you agree with that.

Secretary Thompson. I appreciate it. I agree with you.

PREVENTIVE CARE

Mr. Peterson. The issue of preventive care, I chaired health at the State for 10 years. I want to tell you, I fought the battle there. As we, and I'm all for the research money. But here we are, gaining in research every day, all kinds of cures and new medications that are wonderful and treatments that are wonderful. But we're going backwards on the quality of health in this country because of choices. The American public are not healthier than they were 10 years ago, they're less healthy. They're more obese, they're more out of shape.

But the last strong voice, and I want to say nothing against Mr. Satcher, because everybody tells me he's a brilliant gentleman, I've never mentioned. But nobody has equaled the voice of C. Everett Koop, who we all know, everybody knew, because he was a strong, outspoken advocate on health issues. I know I listened to him all the time. He even inspired me to do things at the State level, as a legislator, from that public presence.

I guess what I'm suggesting to you, in your position, and if you can raise the level of his podium, have him out there more on these issues, CDC has all the data, they have all the information. But it's not really absorbed by the American public.

We need to see the morning talk shows and evening magazine programs with these people, the experts, giving the data, the facts. In sales, sometimes people have to hear the message 10 times before they buy. We forget that in Government. But we need to pound it home that we have more choice, whether we have a serious illness in our lifetime depends more on us than the availability of a doctor or medicine. We don't think like that today. We want a pill to fix everything, medication to fix everything, when behavioral change can absolutely do more for quality of life of health than anything. Am I right?

Secretary Thompson. Yes.

Mr. Peterson. But somehow we have to energize all these government information banks we have and get the general public to understand that they have more to do about their health than the local hospital doctor. It's just their choices. I again would like to work with you on helping somehow market that information.

I don't think you can throw, some of them here would give them half a billion dollars and say, get your information out there. But I think it's going to have to come from leadership like yours, that says, here's how we're going to get it out there. You have the data, you have the information, let's arm the American public with good health, preventive health care information, that they know that their cholesterol level,

whether they have diabetes or not, their blood pressure, all those things are vitally important. I guess the number one growing disease is now prostate cancer with men, it's now surpassed women and cancer deaths. And I know a lot of men in my district don't take that seriously until they have it.

I'd like to work with you on any and all of those issues. I just want to wish you the very best in your job. I'm excited that you're here.

Secretary Thompson. I'm excited, but a little bit overwhelmed. I appreciate your support, no more than your willingness to work with me to try and solve some of these things. You've got great ideas, Congressman, and what I love is ideas, I love to hear from you and see what we can do to implement them and do a better job. That's what I've talked to Chairman Regula about, and he's been so responsive to me, and I appreciate that.

And this whole Committee, I've been in a lot of Congressional Committees, both as a Governor, now as a Secretary. I've never found a tone so complete for bipartisanship than I have this morning as I have on bipartisanship on preventive health and trying to work together to solve some of these things. It must be to the credit of the Chairman and the members of this Committee. And I just offer my support. Let's work together and get something done.

Mr. Peterson. I look forward to working with you.

Mr. Regula. Ms. DeLauro.

Ms. DeLauro. Thank you very much, Mr. Chairman. Welcome, Secretary, a delight to see you again.

Secretary Thompson. My privilege.

Ms. DeLauro. Thank you for all of your great commitments and efforts, and your openness to ideas. That's really very refreshing. Oftentimes in our own offices, you talk to your own staff about ideas, but we don't know everything in these walls. There are lots of good ideas out there that we can take advantage of.

Secretary Thompson. I can confess, I certainly don't.
[Laughter.]

USE OF RESTRAINTS

Ms. DeLauro. Let me mention a couple of areas. I don't know if you've seen the series that appeared, you probably haven't, but I will forward it to you, the Hartford Courant. This was back in October of 1998. They ran a series of articles between about the 11th of October and the 15th. It was a nationwide pattern of death. It was about restraints that are used in some of our mental health facilities and so forth.

This says, ``Rachelle Claiborne pleaded for her life. Slammed down on the floor, Claiborne's arms were yanked across her chest, her wrists gripped from behind by a mental health aide. I can't breathe, the 16 year old gasped. Her last words were ignored.''

They broke a series of stories and I didn't know anything about this. They broke with this series of articles a story about the tragic deaths particularly of young people through the use of restraints, either with people who weren't qualified to use them or the improper use. It was very, very chilling.

So a number of people, in a bipartisan way, were very concerned about the improper use of restraints and seclusion, and these kinds of practices in health care facilities. In 1999, the GAO released a report that found that children are especially targeted by facility staff, and the unsafe practice and are at greater risk for injury or death.

What we did in the Congress last year, almost on a dime and this institution doesn't often work as quickly as you would like, but we responded and we passed national standards. This year, the Department released rules to protect vulnerable children in psychiatric residential treatment facilities. The rules were supposed to become effective on March 23rd. But they have been delayed until May 22nd. During this period of time, we continue to read in the newspapers of youngsters who are dying from this abuse.

What I'd like to have you do is to please take a look at this area, and if you could let us know why the rules were not subject to the waiver under the moratorium that sets emergency or other urgent situations that were related to health and safety. If you can get back on that and we can do something about this, as I say. It is a tragic loss of life. Oftentimes, the kids in these institutions, are about as bereft of any kind of support or any kind of support system. They're often out there pretty much on their own.

If you could take a look at this, I would be appreciative.

Secretary Thompson. I certainly will. Congresswoman, there's no hidden agenda about the delay. There's so much. And I really haven't got a chance to focus on that. I'm trying to move as rapidly as I can. And I think this rule will, if there would be any change it would be to strengthen it.

Ms. DeLauro. Terrific. I understand.

Secretary Thompson. We'll get it out as soon as possible. If there's any problem----

Ms. DeLauro. I'll send you a copy of the articles. Again, when this broke, it was the Hartford Courrant, and our Connecticut Post did an article, did several articles. Everyone was stunned. We just--people began to read these things and take a look at it and say, my God, we can have a role here, we can do something. So thank you very much.

I associate myself with my colleagues this morning on preventive care. We've had a chance to talk about some of this. I look at the areas of alcohol and tobacco, you've got 440,000 people dying from tobacco use or some tobacco related illness in the country, the alcohol usage, the other things that were mentioned here. My gosh, if 440,000 were mowed down somewhere in this country, I think. We would clearly go to war.

Nobody is suggesting that we run folks out of business or that we take away people's livelihoods. But we need to come to grips with the kinds of money that we are spending to look into the causes of illness, and then once we find that out, then we almost do nothing, or very little, to try to address the situation.

Let me ask a LIHEAP question. Connecticut gets cold in the winter. That's serious.

Secretary Thompson. Not as cold as Wisconsin.

Ms. DeLauro. Amen. And I've always been allied with the folks in Wisconsin on this issue on this Committee. The President's budget proposal calls for \$1.4 billion in regular funding for LIHEAP, plus an additional \$300 million in emergency funds. That's about the same level Congress approved last December for fiscal year 2001.

Congress also approved additional help to low income households through a \$600 million supplemental appropriation last summer. All of that money was used. Forty-five million dollars for cooling assistance last summer and \$555 million in the just completed heating season. Emergency funds now depleted, additional funding for cooling this summer would have to come through a supplemental appropriation.

The Administration is not considering any supplemental legislation at this time. I think we're seeing what's happening, but that there isn't much relief in sight for high energy prices. Reducing the available funds for LIHEAP from \$2.2 billion, including the supplemental, to \$1.7 billion, I think has got to be viewed as a cut. I'm asking again if the Administration would be willing to reconsider its position and see if we can offer greater assistance to the poor, to the elderly through this enormously valuable program. Again, something that works well and assists those people who are in very cold climates.

Secretary Thompson. The \$522 million was a carryover, I believe, from the fiscal year before that. So it made it \$2.2 billion, so we put in the same amount of money as the base year fiscal year. The President's spoken very clearly that there will be no supplemental appropriations.

Ms. DeLauro. Well, I'm hopeful that when the problem hits, and it's hit every summer, we've found in Chicago people were dying from the heat and so forth and we had to do something about it with emergency dollars. It may be that we have to get to that point before it happens.

My hope again is prevention of tragedy, it's something when you've had a pattern that you try to do. Again, I'm hopeful that the President might reconsider and if not now, when the heat of the summer is upon us and we are faced with the situation. Thank you very, very much.

Secretary Thompson. I will take your plea to OMB.

Ms. DeLauro. Thanks very, very much. Thank you, Mr. Chairman.

Mr. Regula. Mr. Istook.

Mr. Istook. Thank you, Mr. Chairman.

Secretary Thompson. Hi, Congressman, how are you?

Mr. Istook. I'm doing great, Secretary Thompson. I was coming back from the Capitol with some other members and you were the topic of discussion. Let me just convey, you have a great amount of admiration and respect in this body, not just the service you did, but the creativity you brought to solving major problems in Wisconsin. It's well recognized and well appreciated by me, and by a great many people.

Secretary Thompson. Thank you.

Mr. Istook. You get hard enough hit many different times over things, so you deserve some compliments once in a while, too.

Secretary Thompson. It's very nice once in a while to hear

nice things, yes, Congressman. I appreciate that, thank you.

Mr. Istook. What I don't yet know though is that it's going to be now a job requirement that the HHS Secretary has to be from Wisconsin. I don't know if you're putting that in place.

Secretary Thompson. I don't think so, sir.

Mr. Istook. That will be a relief to some people.

Mr. Regula. If you'll yield, the job requirement is that you have had to be a small town lawyer. [Laughter.]

ABSTINENCE FUNDING

Mr. Istook. Very good. Well, being a lawyer isn't good enough. So I guess I'm safe.

Let me, I know this is an important opportunity with all of us to talk about some of the fundamental and major themes that drive HHS and the agenda, and that you're going to be undertaking. I wanted to take my chance to address several of those.

One thing that I mentioned to you before, and we're receiving very positive feedback from the Administration and OMB right now is concerns over the level of abstinence funding, to promote abstinence, which is broadly supported in a bipartisan way, as a way not only to prevent disease but frankly, to prevent a lot of the problems with which you and so many other people in Government and society have to deal.

I think we're making significant progress, and perhaps having some agreement on putting additional and extra funding in that. I just wanted to express my appreciation for that. I think an ounce of prevention is worth a pound of cure.

Secretary Thompson. Thank you, and let me congratulate you, Congressman, because I know you had an advance appropriation of \$10 million, which is in this budget. I compliment you on your leadership, the President wants to equalize it up to \$135 million from Title X on abstinence. I think that there's a way to get there and hopefully we can accomplish that goal.

MEDICAL RESEARCH GRANTS

Mr. Istook. I think that's terrific, and I look forward to continuing to work on that. I appreciate the diligence that I know people are exercising at HHS to make sure that the grants that are to be awarded are going to those that meet the proper requirements of that, because this is a very important effort.

Let me turn to some other things. You discussed with some of the other members NIH and the elevated funding that's coming forward. I wanted to echo some things that frankly, Mr. Obey said, that have been part of my concern. That is that, with the tremendous increase in medical research funding, sometimes people are discovering ways to treat things but they're not affordable.

People know that there is a cure possible, and certainly if they believe that some sort of cure or treatment is possible, they want to make it available. But it may be priced in a way that either they cannot afford it or if the Government or an insurance carrier or some other provider pays for it, creates part of the medical inflation we're experiencing.

There's been some reports recently sponsored by Blue Cross that indicate that a significant amount of medical inflation

that we're having right now is being driven by the medical research and the new things that it makes possible, even if it's a challenge to afford them. So one thing that I certainly am trying to encourage is that we start making a devoted and a focused effort as part of these increased dollars going to NIH to put a significant portion of that research into finding ways to make treatments affordable, whether it be changing something about the mode of treatment or frequency, I don't know.

But there's often many ways that researchers can find, if they're given the resources, not just to find new treatments or new information, but to find ways to make it more affordable. I think that's a very significant and important part, hopefully, of the future NIH budgeting.

Another aspect of that is that sometimes the benefits of medical research are not disseminated everywhere. We have a situation where half of the NIH research grants are going to research institutions in five States. Now, there are more than one-tenth the population----

Secretary Thompson. Say that again?

Mr. Istook. That's right, more than half of the research grants out of NIH go to five States. The other States have to share the other half. In fact, for about half of the States, 25, 26 of the States, collectively receive, I'm not sure of the current figure, it's approximately 8 percent, 7. Approximately 8 percent, 7.7 percent I'm told.

Now, I realize that's not weighted for population, those particular statistics. But I think it tells a tale that we're not making sure that the advantages of medical research are going to institutions that are spread out across the country. Hopefully institutions that are involved also in clinical practices so that physicians that are associated with each other receive through that contact the benefits of medical research, that it's being disseminated throughout the country, not just something that may be a scholarly publication that is never seen. But that it's in enough places that people are rubbing shoulders and getting the information.

With that in mind, I've been working with an EPSCOR or IDEA effort within NIH to make sure that the States which have been on the disadvantaged side of that are----

Secretary Thompson. I presume your State is one of those.

Mr. Istook. You are correct, sir.

And as I say, there's half the States in this situation. But it is the opportunity to make sure that this tremendous investment in medical research is shared throughout the country. As I mentioned to you, the figures on the numbers of States I realize is not the same as when you adjust for population. But even when you make that adjustment, I think there's a significant problem and that the time of increase in funding is the time to make sure that problem is addressed. Because otherwise, people feel they have a vested interest, that they've already received certain shares of funding.

Secretary Thompson. So you worked with the IDEA program. You know, the President put in an additional \$135 million into this budget to make it better.

Mr. Istook. I wish it were an additional \$135 million. I think it's an additional \$35 million. I've been working on this, we've got it up to a hundred, would like to get it up to

a couple of hundred. But the important thing is to explain to you what's going on here. I think it is a good idea, and I'll pass on to people that you said that. Because it's not simply a funding matter.

Secretary Thompson. What are the five States?

Mr. Istook. Let's see if I can give them correctly here. It's Maryland, Massachusetts, California, Pennsylvania, and New York.

Secretary Thompson. Now I know it's an even better idea. [Laughter.]

Mr. Regula. We'll have equal time here.

Mr. Istook. I understand that.

But it is something that make sure that this percolates throughout the country. Because we want the advantages of it to be there.

Secretary Thompson. Absolutely.

Mr. Istook. And we want it to be affordable. I think making some focus within NIH is part of that.

If I might have 30 seconds, Mr. Chairman, just to express, there is, as you know, a lot of concern with funding formulas involving HCFA, and whether it stays HCFA or goes to MAMA or whatever it might be in the future.

But there is certainly a concern that the formulas, which I know involves Congress, not just HHS, the formulas, the weight in them, some of the historical factors they take into play, is causing a lot of disparity. Oklahoma, yes, is one of those States that is hurt tremendously, and it creates problems in health care, creates problems in nursing homes.

We've had some convictions in Oklahoma recently with some nursing home operators involving bribery, who felt the pressure to try to get extra funding. They went far beyond what the law allows on that. I don't want that kind of temptation, but more than that, I don't want that kind of problems with the disparities. We have enough red tape involved in the funding formulas. Some hospital administrators from Oklahoma who heard you speak yesterday were very optimistic about your approach to bringing some more common sense into those.

But I just wanted to express those concerns and hope that we can work together and make sure again that everyone has an equal opportunity and equal consideration in these formulas.

Secretary Thompson. Congressman, I thank you for your comments. The disparity in funding is something that's been a bother to me as a Governor for many years, because Wisconsin was like Oklahoma. But this is really in the purview of Congress. I can't change the law and the equalization of payments has to come through some kind of Congressional change.

Mr. Istook. I understand that. I do know that the degree of understanding that you can help be made known to people, though, is very important, because you're a major source of information for this, you and your agency.

Secretary Thompson. Thank you for your comments and your questions.

Mr. Regula. Just as a follow-up, does NIH work with the universities, on how they can be better qualified to get grants, so that we can get a better spread of this research money?

Secretary Thompson. NIH does, maybe not as complete as it

should, but that's what the IDEA fund is set up to do. HRSA and AHRQ also get out information on how to apply for grants.

Mr. Istook. If I may, Mr. Chairman, I ought to say to the Secretary, Dr. Kirschstein has certainly been very positively disposed toward this effort, and we appreciate that.

Mr. Regula. The gentlelady from California.

Ms. Pelosi. Thank you, Mr. Chairman. Did I detect a challenge in your voice? [Laughter.]

Thank you, Mr. Chairman.

Mr. Secretary, congratulations to you on assuming this very, very important position. I wish you much success, as I know all of my colleagues have expressed to you as well. Good luck.

Secretary Thompson. Thank you.

PREVENTIVE HEALTH

Ms. Pelosi. A couple of things, I wanted to associate myself with Mr. Kennedy's remarks about parity in mental health. It's an issue that we've all long fought for. Some of the other issues that were raised in terms of addiction, obesity, smoking, etc., I just want to make one point on that.

I think kids are very smart. We tell kids that smoking is bad for their health, and then we're surprised when they don't stop smoking, when we don't really give many kids access to quality health care. So if we want to place a value on their health, we've got to be consistent in how we do it, not just stop smoking, but here you are in the loop of access to quality health care.

So I think we'll have a stronger message when it's a more consistent message of the value that we all place on health. I think the same is true of schools, when we send the kids to schools that are not in good shape and tell them that education is important. But we haven't placed a value in it from a budget standpoint. But anyway, that's just my soapbox on that for the moment.

I had a couple of questions, but I wanted to address the concern Mr. Istook had, and I certainly associate myself with his concern. I will say that we have, these are competitive grants and that in our State, being the largest State in the Union, I don't know where we figure in that five, but we certainly have huge investments in having excellent centers of research so that we can compete on a scientific level.

I think it's very important to make the investments in other States so they would have the absorbed capacity for these grants as well as the strong science to compete for them. But we have to keep this on the basis of science, but recognize that these estimates have to be made.

Secretary Thompson. Absolutely. No question about that.

HIV/AIDS

Ms. Pelosi. I wanted to express a concern, Mr. Secretary, with all due respect and good wishes to you, I unfortunately was detained and I didn't hear your oral presentation. But I read your statement and I was concerned that the word AIDS and HIV were not mentioned in it at all.

Secretary Thompson. I spoke about it.

Ms. Pelosi. I do know that in your statement that you made here, you did mention it, and I want to address what you said. The Administration has been saying that HIV-AIDS are a priority and in your remarks you cited a 7 percent increase. That 7 percent largely is in research at NIH and that's very, very important, and for mandatory spending under--but Ryan White and domestic prevention and minority HIV health initiatives are just about flat funded. Of course, this amounts to a decrease in terms of meeting the needs of people after you go through inflation.

So if it's a priority, I think that there are ways of tangibilizing that good intention in the budget. That means more money. And if it is a priority, I hope that it would be more part of your presentation, because it certainly is a very important challenge that we have, and I know that it is a priority for you. But this budget number is just barely meeting inflation, not in any way meeting the increased need.

And if I just may address what they are, in prevention, 40,000 new HIV infections occur each year domestically, half of them among young people under 25. And in the ADAP program, the drug program, 10 States currently have waiting lists for this program. We need to redress that. So the flat funding doesn't take us there, and it's hard to see how that's a priority.

Secretary Thompson. May I respond?

Ms. Pelosi. Please do.

Secretary Thompson. This is an issue of great importance to me, one I'm very passionate about. There are 36 million people in the world that have AIDS or HIV, 25.1 million are in Africa. Only 1 million people across this world are getting any kind of treatment whatsoever.

Thirteen million orphans since 1999, 12 million are in Africa. Forty-three thousand of the new people that get TB, 43 percent of the new people who get TB in the United States are from countries that have an epidemic in AIDS. If we don't control it in Africa, there's 3 million people in India, it's going to go into Afghanistan, it's going to go into China, it's going to go into Russia, it's going to go to Brazil. And we're going to have a tremendous problem.

We have to do something about it. And I just don't think putting more money into Ryan White at this time is the answer. I think we have to find a vaccine to prevent it.

Ms. Pelosi. Glad to hear you say that. That's my bill.

Secretary Thompson. That's why we put the money in NIH. I happen to be a big supporter of Ryan White and the ADAP program. I put extra State money, when I was Governor, into the program, over and above the money I got from the Federal Government to do that. You'll notice that there's not a waiting list in the State of Wisconsin. It's a program, and Colin Powell, the President and I are setting up a joint commission, and I'm going to be leading a group to Africa, and I would love to have you go along with us.

Ms. Pelosi. I would love to.

Secretary Thompson. And see what we can do. I think once you're there, once you see the problem, you will also be supporting, hopefully, an international fund that we are going to have to set up somehow to get not only the United States,

but the international community motivated to do something. It is a serious epidemic. And some countries, more than likely, will fail if in fact we don't do it.

Ms. Pelosi. I really appreciate your depth of knowledge on the subject and your commitment. But you should know also, Mr. Chairman, since I came to Congress 14 years ago, over 13,000 people have died in my district of AIDS, 13,000, 14 years ago. We tried to spare the rest of the country and the world that. We beat the drum for international, the AIDS issue, many, many years ago. I was very disappointed that it did not rise to the level of the G7 year ago, when we asked the Secretary of Treasury, Jim Baker, and we asked the Secretary of Treasury when it was Secretary Bentsen. And now it finally is at that level. This could have been avoided. The world leadership did not make the commitment.

Secretary Thompson. You were a visionary, Congresswoman.

Ms. Pelosi. And all the money that we have for international AIDS we got in my other bill, where I was ranking member in foreign operations. Never enough, but the most we could get and fight for. So I would love to go to Africa with you so we can make progress on this issue. But our district has been educating the world on this issue for a very long time.

Secretary Thompson. I know it has.

Ms. Pelosi. Sadly from our experience that we didn't want anybody else to have.

But I'm not just talking about Ryan White. I think we need more funding for the ADAP.

But we also have to have domestic prevention. Now, I have a bill on the vaccine which we tried to get in the tax bill for incentives for the private sector to invest in a vaccine for HIV-AIDS. We haven't been successful yet, but we're trying on that score.

And of course, the increased funding at NIH for that research is very important as well. So I'm glad that you have it as a priority. Because prevention, prevention, prevention is a priority. Domestic prevention, which I hope will be at the end of the day better funded from our Chairman here, and also the minority HIV-AIDS initiative, recognizing the newer face of HIV in our country.

Secretary Thompson. Seventy percent of the new cases are minorities.

CHILD CARE DEVELOPMENT BLOCK GRANT

Ms. Pelosi. That's right. That's why we have this minority AIDS initiative that came from this Committee. The Chairman, I'm not sure what my time is, but I just want to put on the record issues of concern that perhaps we can follow up on another time. And that is, the CDC's national exposure report was a significant step forward. Lou Stokes, Mr. Chairman, as you recall, was here on behalf of Pew Commission, describing the need to expand CDC's efforts to develop coordinated nationwide health tracking network. I'd like to talk to you about that at some point.

And also I'm concerned about the President's budget proposals and increases for child care development block grant. Four hundred million, though, is marked for school programs,

which are important. But that is not, as a result, existing child care programs are cut by \$200 million. So hopefully we can redress that in our budget this year.

Secretary Thompson. I have to disagree with you on that. We put in an additional \$200 million in the child block grant, went from \$2 billion to \$2.2 billion. But then we earmarked \$400 million of the \$2.2 billion. But there's still a 10 percent increase, from \$2 billion to \$2.2 billion. And we expanded the program from 13 to 19 for those kids after school. So another 500,000 kids will be taken care of after school.

AFTER SCHOOL PROGRAM

Ms. Pelosi. And the after school program is something that we all advocate for. But when you say it's still a 10 percent increase, it's something that we'll have to work through our budget process here, so that when we have an increase, it really is where it is.

In closing, Mr. Secretary, and I'll say to the Chairman, this is lamb eat lamb, this Committee. There's every good thing in here. If we have a cap on our spending, everything that is competing is something you would fight your heart out for. So there's no bad thing. It's just that when we say it's an increase, we want to make sure that that's what it is, and when we say it's a priority, we want to make sure that's what it is.

But again, I really am so delighted to hear of your commitments on the AIDS issue. It's not a surprise to me, but I love the reiteration of it, and look forward to working with you and wish you every success. Thank you.

Mr. Regula. Ms. Pelosi, we're going to try to love our neighbor.

Ms. Pelosi. That's where we started. We love God and we love our neighbor. And we define our neighbor as not only the person who lives next door to us, but every person on the face of the earth, right, all God's children.

EARLY READING FIRST

Mr. Regula. I think that was the intent of the statement in the Bible.

Mr. Secretary, you've been extremely generous with your time. I don't want to prolong it. As you can see, this Committee is dedicated. I think we have excellent Members. They care about the things that you do, and they want to be a partner with you in helping people. We'll look forward to continued dialogue through oversight and so on.

Just one thing I did want to ask about was the Early Reading First proposal. Because HHS has the Head Start program. I've often thought it probably should be in Education, but it's at HHS and I can understand why, because Head Start has many elements in addition to reading, writing and arithmetic. It's getting the parents involved in the welfare of the child.

I'm not sure I know how Head Start and Early Reading First fit together.

Secretary Thompson. Are you talking about the new program the President put into Education?

Mr. Regula. Yes, he proposed Early Reading First, in the

Education part of the bill. I don't know whether it overlaps with Head Start or whether there is a coordination of this proposal.

Secretary Thompson. No, not really. The President is passionate about making sure that every child learns how to read. He thinks that's the cornerstone of a good education.

Mr. Regula. Absolutely he's right.

Secretary Thompson. I agree with him. He wants to highlight and stress reading. And he did not give it to us in our Department. I requested it, but it went to the Department of Education. And we want to work with the Department of Education. We think we developed a true Head Start and reading program, we can develop even a better program.

Mr. Regula. Well, I like your comments earlier about cross-checking and cross-working with other Departments.

Secretary Thompson. I don't think we do enough of that.

Mr. Regula. As you know from your experience, turf gets very sensitive in a political arena. But it's people we need to care about, and not so much about whose turf is being involved and invaded. So I like what you're saying.

I'll put a number of questions in the record, because I don't want to hold you up. You've been more than generous with your time.

I just want to say that I've admired you from afar, that is Ohio. [Laughter.]

My faith, as I discover, is not misplaced. I think you've been very impressive this morning. Mr. Istook mentioned, and I had the same experience walking over to vote, that people who had been here during the morning were very complimentary.

We really look forward to working with you and I think that the country will be well served. Thank you for coming.

Secretary Thompson. Thank you, Mr. Chairman, for your kindness, both your comments but also your kindness to me when I come to visit you. I'm looking forward to it. I just would have to reiterate what I said this morning. This Committee has been a wonderful experience for me to come in front of, because I haven't sensed the tone of bipartisanship as complete in other committees as I have here today. It's been very refreshing to me.

Mr. Regula. Well, we're both on a learning curve. This is my first experience in this Committee.

Secretary Thompson. Nothing a small town lawyer shouldn't be able to handle. [Laughter.]

Mr. Regula. That's right, thank you. With that, the hearing is adjourned.

[The following questions were submitted to be answered for the record:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Wednesday, May 9, 2001.

HEALTH CARE FINANCING ADMINISTRATION

WITNESSES

MICHAEL Mc MULLAN, ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

ELAINE M. RAUBACH, DIRECTOR, BUDGET AND ANALYSIS GROUP, HEALTH CARE FINANCING ADMINISTRATION

DENNIS P. WILLIAMS, ACTING ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Regula. We'll get started this morning. Welcome, Ms. McMullan, Ms. Raubach, and Mr. Williams. We have a very important topic this morning.

Opening Statement

Ms. McMullan. Good morning, Mr. Chairman. I'm Michael McMullan, the Acting Deputy Administrator for the Health Care Financing Administration. I'm honored to be here today to present HCFA's fiscal year 2002 budget request and to answer any questions that you have.

HCFA'S ACCOMPLISHMENTS

First, I'd like to tell you about some of our recent successes and some of the challenges that lie ahead for the Agency. As always, we appreciate your support and look forward to working with Members of the Committee.

Our first chart highlights a few of our recent accomplishments. I would like to mention just a couple of them, starting with the Government-wide award winning Medicare.gov website. This has been cited as the best Government site for health care issues.

We have made progress reducing the fee-for-service payment error rate toward our goal of a 5 percent error rate. Last year, our Medicare fee-for-service claims payment error rate was less than 7 percent, half of the error rate in 1996, and below the target for our fiscal year 2000 performance goal. While we strive to pay claims correctly the first time, with the billions of claims and very sophisticated payment systems, some errors occur. We want to address honest billing errors through good program management and business practices and improved provider education and communication.

Our Medicare & You Handbook has been recognized for being written in plain, easy to understand language. We have left copies of this handbook for each of the Members in your chairs to introduce you to the work that we do to better inform people with Medicare about their health care choices.

Mr. Regula. Is there one for each State?

Ms. McMullan. Yes, there is one for each State, and we put the State specific one in each chair.

We have also strengthened our oversight function. Our nursing home initiative, now known as the Nursing Home Oversight Improvement Program, has helped reduce the use of restraints in nursing homes and has improved the quality of care for nursing home residents. We have made progress, but a lot of work remains to be done. Our workload grows each year.

In fiscal year 2002, we expect to pay almost 1 billion Medicare claims, process over 7 million appeals, answer 40

million inquiries and manage and update 75 different claims processing systems. We oversee 17,000 nursing homes, conduct inspections and complaint investigations for 65,000 health care facilities and almost 13,000 clinical laboratories. We will also distribute 40 million Medicare & You handbooks and answer 5 million calls on our Medicare+Choice 1-800 number.

HCFA's BUDGET PRIORITIES

One of our highest priorities is modernizing and stabilizing our Medicare claims processing systems. Our systems are rooted in the 1970s, when we processed only a fraction of the claims that we processed today. These systems are based on outdated technology that is expensive and difficult to maintain. Our ability to keep up with the increasingly complex and rapid pace of change in our programs depends on stabilizing and modernizing these systems and expanding their capabilities.

Another priority is improving our financial management systems. HCFA spends hundreds of billions of dollars each year on Medicare benefits, yet our Medicare contractors use ad hoc, piecemeal systems to account for these funds. The General Accounting Office and the Office of the Inspector General have both expressed concerns about HCFA's current financial management systems, stating that they are simply inadequate for detecting and collecting debt, for retaining a clean audit opinion and for complying with statutory requirements.

We ask for funding in Fiscal Year 2002 to begin building a uniform accounting system at the Medicare contractors, and to replace our administrative financial systems. This system modernization is a multi-year commitment. With billions of trust fund dollars at stake, we believe that it's worth the investment.

We want to make our national coverage determination process more open, understandable and predictable and to reduce the time that it takes to reach an official decision. We are also working with physicians to reduce unnecessary regulatory and administrative burdens. HCFA now has a team that will work with physicians to identify these issues and resolve them. We will continue to work with States on their nursing home inspections.

As we face these many workload challenges, we recognize the need to manage our human capital responsibly. Forty percent of our current workforce can retire by 2006, taking with them valuable institutional knowledge. We are developing a workforce planning process to ensure that in the coming years we have the right number of people with the right skills and in the right jobs.

GOVERNMENT PERFORMANCE AND RESULTS ACT

Finally, I would like to say a word about the Government Performance and Results Act and our Annual Performance Plan. You can see from our chart that we have performance goals for each of our programs. We continue to work to integrate the budget with these goals. In 2000, we met or exceeded 20 of the 25 goals for which we have complete data, and we have added four new goals for 2002.

HCFA'S DISCRETIONARY REQUEST

This brings me to our request. We are asking for \$2.351 billion for Program Management, a 4.9 percent increase, or \$109 million, over our fiscal year 2001 appropriation. Most of this increase is targeted for the Medicare contractors who process almost a billion claims a year. Some of the increase will help us improve our information technology infrastructure, and some of it is for the new accounting system that I mentioned earlier. The balance is for implementing new legislation and for covering our payroll expenses.

To put this request in context, we have a constant dollar chart which shows that our budget request really only brings us up to the fiscal year 1992 funding level. Our workloads and responsibilities on the other hand have grown substantially in the last 10 years. In fiscal year 2002, HCFA's programs will pay out close to \$400 billion in benefits, second only to the Social Security Administration in the level of Federal spending.

The programs administered by HCFA affect the Nation's health care economy and millions of people in the health care pyramid. This pyramid is our final chart. Let us start with the 4,600 employees. These employees leverage the efforts of more than 64,000 State and private sector employees who in turn deal with over 1 million providers, serving 70 million beneficiaries. HCFA must have an adequate level of funding to ensure that its programs are strong, well-managed and responsive. I am confident that this request will provide us with the resources and flexibility we need to meet this challenge.

Thank you for the opportunity to present HCFA's fiscal year 2002 budget request. I look forward to working with the Committee and I'm prepared to answer your questions. Thank you.

The information follows:

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Mr. Regula. I think we'll recess for the vote and come right back, well, we can take two minutes before we have to go. Mrs. Pelosi.

EARLY TREATMENT OF HIV

Ms. Pelosi. I look forward to the cooperation of HCFA. I had a question about HIV and AIDS. New HIV/AIDS treatments have improved both the health and quality of life for many people living with HIV/AIDS. However, many uninsured Americans still do not have access to these life-saving medications because childless adults generally do not meet Medicaid requirements until they are disabled by full-blown AIDS. We know that early treatment saves lives and reduces health care costs as progression from HIV to full-blown AIDS is prevented or delayed, and there is a pressing need to eliminate treatment barriers for vulnerable populations.

Representative Gephardt and I will soon be introducing the

Early Treatment for HIV Act which allows low-income individuals living with HIV to qualify for Medicaid coverage earlier in the course of their disease. I hope that we can work together to ensure that low-income, uninsured people living with HIV are covered by Medicaid and are able to receive the treatment they need to stay healthy.

Ms. McMullan. We will be glad to provide any technical assistance you need in preparing that legislative request. And we'll be happy to work with you.

SOLVENCY OF THE MEDICARE TRUST FUNDS

Ms. Pelosi. The next question I have is, does the President's budget do anything to extend the solvency of Medicare? As the baby boomers begin to retire, it is well known that Medicare requires resources outside of the current program in order to ensure its long-term solvency. Yet the President's budget does not provide additional resources. In addition, the budget conference agreement appears to allow the Medicare Hospital Insurance Trust Fund to be tapped for the prescription drug and ``Medicare Reform'' package.

We all agree that Congress must enact a prescription drug benefit for seniors, but should this be done at the expense of Medicare's solvency?

Ms. McMullan. The current projection for the solvency of the trust fund has it extended to 2029. Anything, depending on any proposals that Congress would agree to on prescription drug coverage or any other changes to Medicare could affect that projection. But without knowing what those are, our current projection for exhausting the trust fund is 2029.

Ms. Pelosi. If that is to be a source of funds for the prescription drug benefit, I just want to put that in the record.

Ms. McMullan. That determination would be made by Congress, when the law funding this benefit is enacted.

Ms. Pelosi. Thank you, Mr. Chairman. I will mark it down.
[Laughter.]

Mr. Regula. Okay, we'll recess to go vote and come back.

[Recess.]

Mr. Regula. We will reconvene. Mr. Peterson?

PAYMENT DISPARITIES IN RURAL AREAS

Mr. Peterson. Good morning. Welcome.

I'm from Pennsylvania, I represent a very rural, rural area, about 20 percent of Pennsylvania. I have 16 hospitals and countless nursing homes and home health care agencies in my district.

I guess the question I would like to ask, from your opinion, how did we get to the situation where, in urban America, we have Medicare Plus Plus, suburban American, we have Medicare Plus, and in rural America, we have Medicare Lite? And I mean, you can't describe it any other way. How did we get there? That rural gets so significantly less much payment for the same services? How did that happen?

Ms. McMullan. There's a long history of the way the payment systems have been developed. Significantly, payment systems

rely on cost reporting information from the institutions themselves and the wages that are paid in rural areas, as well as some of the other costs, have influenced payments in the past. In some of the recent legislation, even in previous legislation, Congress has done a great deal to try to balance some of the rural-urban payment differences. And there is more parity developing in the systems. But it has its roots in payment formulas that have relied on the cost reporting information from the institutions themselves.

Mr. Peterson. Does health care consumed have something to do with it, per person, history of consumption? I mean, rural America has historically, does not go to the doctor as quick as suburban or urban people for some reason. They're further away from them, I guess, have not consumed, they were a younger population. Today it's our senior population. I mean, rural America is the senior population in this country who are going to consume a huge amount of health care.

And the number one threat to rural health care being alive and viable is the unfair Medicare and Medicaid payment.

Ms. McMullan. What we can do is supply you some of the findings of recent studies on what has changed and what other kinds of changes are needed. I can't answer the question on the effect of consumption.

Mr. Peterson. I think it is. I think it is a factor. But is this formula determined all from legislation, or is part of it regulatory?

Ms. McMullan. Virtually all components of the payment systems are statutory. There are some judgment issues, but the structure of our payment formulas are set by statute.

Mr. Peterson. Because what was happening in this country, and we've been trying to stem that in recent years, that is, as rural health care goes broke or out of business, the patients go to the suburban marketplace and you pay significantly more. So nobody wins. Rural health care loses its health care at home where it ought to be, close to home, goes to the suburban marketplace, where you pay significantly more for the same service.

It would seem to me that if I were running HCFA, I would be strategizing as a business person how to provide my care in the most cost-effective, quality way as possible. And I'll stack rural health care quality wise up against anybody's health care, on the average. But they certainly have been discriminated against, in my view. Usually when you deal with sparsity in education or other issues, you add money to the pot because it costs more to serve a rural area. In health care, it's significantly less. Your patients are farther apart, farther from the health care, and you may not have as many people using a sophisticated device, you pay them less. So you deprive them of the service, in my view.

This is not personal. You're just here for the agency today. So I guess the whole thought process, in my view, is certainly, if I was running HCFA, I would be trying to figure out ways to cost effectively provide the care.

Ms. McMullan. There are work groups dealing with the rural health issue. And as I say, I'll be glad to provide you with some of the findings of the studies and some of the issues that they have determined.

RURAL REPRESENTATION

Mr. Peterson. I guess the other thing, on most your panels and boards, do you absolutely make sure that a fair representation of rural people are on those panels and boards? I see you shaking heads yes, but I often hear no.

Ms. McMullan. Under the Federal Advisory Committee Act, when we seek members of public boards, we look for representation of the community that we serve. And to my knowledge, we have gone out of our way to make sure that we have at least a single, if not more than one, rural representative on each.

Mr. Peterson. Yes, but a huge part of America lives, in Pennsylvania, a third of the population lives in towns of 2,500 or less. I mean, a huge part of America is rural. But we're so urban driven that we're not often at the table.

PROVIDER COMMUNICATIONS

I'll move on to the next issue. I've been in public policy for too long, I guess, I was at the State for 19 years. I chaired health, so I'm familiar with your 50 Medicaid programs that you also play a role in. Has there been an effort at HCFA to figure out a way for health care providers to talk to you and deal with you? Somebody local that they can deal with the immense complexities of your programs and your rules and your regulations? I find health care providers just reacting and reeling all the time from the new HCFA rules, the new wave of paperwork. And there's nobody, if they don't have a legislator that's interested in health care, they don't have anybody to talk to, in my view. Would you respond to that?

Ms. McMullan. We have several different activities to address the needs of providers to make sure that we get them the information they need. We have provider education efforts, where we are aggressively trying to reach out to the provider community and tell them about any changes that are made in the way that we administer the programs.

We do that both directly through our contractors, through the regional offices and through national telephone calls and satellite broadcasts to answer those questions. We also are building a significant capacity on our website, so that providers have access through the internet.

In addition, each of the contractors is required to have a committee of representatives to meet with provider representatives, so that they can tell them about changes that are occurring in the way we implement our program. We are interested in anything else that might be useful, because communication with providers is one of our primary responsibilities. Unless providers know how to bill correctly, it's to our disadvantage, the program's disadvantage, as well as theirs. So we're very anxious to do as good a job in that area as we can.

Mr. Peterson. If my hospital has a real quarrel with an intermediary, where do they go?

Ms. McMullan. The regional office first, and then if they're not satisfied---

Mr. Peterson. For Pennsylvania, that's Philadelphia.

Ms. McMullan. Yes. Then if they're not satisfied, they can come into the central office.

Mr. Peterson. Who would they end up talking to if they called Philadelphia?

Ms. McMullan. There are people in each region who specialize in the Medicare program, the Medicaid program, and the different aspects of the programs that we administer in HCFA. And if they had a hospital question, they would get a Medicare expert.

Mr. Peterson. Would you furnish me with the Philadelphia office listing of who people would talk to for the right situation? I don't think that information is readily available to providers, and it ought to be.

Ms. McMullan. We'll provide that.

Mr. Peterson. Okay, thank you.

[The information follows:]

Philadelphia Regional Office Contacts

The following Regional Office employees are specialists in HCFA's programs:

Peter Goodman--Beneficiary Services Branch Chief and Acting Contractor/Provider Branch Chief: 215-861-4215.

Carol Messick--Public Affairs Specialist: 215-861-4244.

Mr. Regula. Mrs. Northup.

SCHIP WAIVERS

Mrs. Northup. Thank you. Congress passed the SCHIP program in an effort to ensure that more children were covered. We all know that States have grappled, with different amounts of success, with attracting more children into this program.

It's my understanding that the legislation was very prescriptive about what the benefits needed to be, which has eliminated or at least restrained from States any flexibility. States that wanted to combine the SCHIP funds with, say, private insurance funds that are accessible through the workplace have been unable to do so.

Can you comment on the problems States have had in getting a waiver and what sort of provisions we might need to include in legislation that would expand the sort of delivery systems they can use to deliver SCHIP services?

Ms. McMullan. As far as SCHIP implementation, we have been working closely with the States to help them implement the SCHIP program, including processing the requests for waivers in the SCHIP program. As far as any legislative proposals, I would have to provide that to you separately. I'm just not familiar enough with that aspect to be able to answer your question, as to think about what we have suggested to Congress that might improve the program.

Mrs. Northup. Well, specifically, I think that the concern is there are sort of two ways we can go. We can try to attract every American into public health, either in Medicare, Medicaid, deliver more services, mandate more prevention services, more people would be entitled to government health

care. And we tend to do that, which of course is bankrupting some of our systems.

Or we can try to help leverage the public dollars to help people access the private health insurance market, and therefore have more choices about where they go, where they get their services. Specifically, in Kentucky, we asked for a waiver, would have liked to, for example, have subsidized a family plan for a working family, a family that had a member of the family that was working in it, was employed and was able to get family coverage, but couldn't afford family coverage. And maybe this family would have liked to have just expanded their coverage to family coverage so that their children would now have coverage for a fraction of the dollars that it takes to include them in the Medicaid program.

We couldn't get that waiver. And so now every child in Kentucky that's entitled to the SCHIP funds gets it through Medicaid, a much more expensive delivery system. And quite frankly, many of their families feel less inclined to opt for employer based insurance if they have to share in the cost, and if their children already have coverage through another means. Other families don't take advantage of SCHIP because they quite frankly don't want to be in Medicaid. They're now privately employed, they go to their own doctor, that's what they want their children to do. Since that door is closed for them, they don't take advantage of the SCHIP funds.

But I think what's of most concern to me is whether or not we're using the public funds as efficiently as we could if for a fraction of the dollars we could expand individual coverage to family coverage. Clearly we could stretch our Medicaid dollars further.

My concern is, when I've asked the Administrator about this, what I have been told is that the language in the law is very specific about what sort of coverage every child has to have, and that because private insurance plans clearly don't cover what Medicaid does, I mean, Medicaid pays for the taxi to take you to the doctor, that private insurance coverage doesn't meet the legal specifications of the law. So that sort of flexibility is lost.

Does that sound familiar to you at all?

Ms. McMullan. Medicaid and SCHIP rules are complicated at a level that I don't fully understand. I would be happy to set up and arrange a briefing for your staff on your issues, so that they can be explained more fully by people who are more expert than I.

Mrs. Northup. I think I want more than that. I want recommendations of what changes in the law would allow more flexibility, so that State waivers would have a better chance of being approved. Many of our States are desperate about the negative balance they have in Medicaid, and desperately need to be able to employ some of these new strategies, so that they do not find that the costs of these programs are sinking their State budgets.

So I'm not really as eager to understand what the obstacles are as I am to know what sort of statutory changes would have to be made, so that we could eliminate those obstacles.

Ms. McMullan. We'd be happy to provide whatever technical assistance we can.

Mrs. Northup. Okay.
Thank you, Mr. Chairman.
Mr. Regula. Mr. Miller.

PROVIDER IDENTIFICATION NUMBERS

Mr. Miller. Good morning. Let me start off with a question that's, HCFA's been a great frustration to many people in my district, a large number of elderly in my area, Sarasota, Florida, Manatee County, Florida. And one was one from the medical society, that it takes too long to get a provider number. This is a fairly specific type of problem.

But the frustration they have, and apparently this is not just in Sarasota County, because they said it was a big issue at a national physician meeting, is that for example, a group in Venice, Florida, several physicians broke up their practice, continued practicing in the same town, it took them four months to get a new provider number. It was so frustrating for them, they had been in the system, but it was a group. But they felt it was a bureaucratic problem.

There was another case of a doctor moving just from St. Pete down to Sarasota, same problem, just took months to get that number.

So those are kind of some of the frustrations they have, that with HCFA, and the day to day issues, it's not a partisan policy type issue, but it's just that frustration. So I'm just sharing it with you, I'm not sure there's an answer to it or anything, but to let you know, those are the type problems that just kind of drive people, kind of upset with you.

MEDICARE+CHOICE PLAN WITHDRAWALS

Another issue in my area is these choices, and I was just reading this book, it's interesting, I have six more year and I'll be eligible for this book. It's interesting to follow it. But in my area, we have no choices. They've all been driven out, basically. And is there any hope? We've passed some more money the past couple of years. Is there any chance any of these are going to come back into areas that they dropped out of? I mean, what's the future there, especially in medical savings accounts, which don't even exist, even though they're somewhere in the law? Can you comment about choices?

Ms. McMullan. We are working hard to understand what the administrative burdens are, and what other kinds of issues are creating difficulties for Medicare+Choice plans to operate within different areas of the country. And we're working closely with the industry to understand those things.

Some of the issues can be remedied by changes in statute. Some of the issues are things that can be remedied by our doing business differently with the Medicare+Choice plans. Some issues involve having access to provider networks, which is something that the managed care industry and the Medicare+Choice plans need to understand at a local level.

It is a priority of this Administration to look at ways to work better with the Medicare+Choice organizations. We have had no interest in medical savings accounts.

MEDICAL SAVINGS ACCOUNTS

Mr. Miller. You don't mean HCFA has no interest----

Ms. McMullan. No, no. We've gotten no applications. No insurance company has approached the agency.

Mr. Miller. Why?

Ms. McMullan. I can only assume that it's not a good business choice.

Mr. Miller. Or is it because of the way it's structured, that there's no choice, I mean, it just makes it very unattractive? Well, I mean, it's not available. Some people would like to have that as an option, which is just a catastrophic type of insurance plan. It must be the way it's structured. And maybe it's the way the law was written too.

BENEFIT PLAN CHOICES

I just believe people should have choices. I just think everybody should have the right to choose whatever they want. If you don't like HMOs, stay away from HMOs. But if you want to join an HMO, some people love them, you should have the right to choose them. We've just lost all of our choices in my area of Florida, for a variety of reasons. It's very frustrating for those that had an HMO and had to go out of it, and they can't even switch to one, because there's nothing really available in my area.

CRIMINALIZING MEDICAL PRACTICE

Let me ask a question I've had that people complain that, we've had a lot of fraud. And you've made some progress in reducing that. But a lot of people feel we've criminalized health care practice. The physicians say, my gosh, it's criminal. They give some illustrations back in my district. Doctors are afraid to practice, because they're made a criminal for some issue. We want to crack down on fraud, but yet maybe we've gone over. Do you feel there's any problem with that as far as allowing the physicians to practice medicine rather than worrying about going to jail, the threat approach rather than working together?

Ms. McMullan. The criticism of criminalizing the system, we're very familiar with that. We are changing some of the rhetoric that we use to make sure that people understand that we really are trying to work within the system to reduce the number of payment errors. Many of the errors are very honest errors, made by not understanding the system. We're investing a lot of energy into the education of provider groups, so that they can understand exactly what the rules are, so mistakes do not occur and we can avoid creating any kind of tension within the system.

So we are conscious of the concern and we are working to change the dynamic. It is important, because of the entirety of our program and the trust fund, that we deal with payment errors and make sure that they don't occur. But our greatest tool in doing that is education and communication with the provider community.

Mr. Miller. Well, I hope you make some progress. Because

right now, they're worried if they make a billing error and it's not intentional, all of a sudden they're threatened with jail. They say, wait a minute, wait a minute, I want to practice medicine. There are the ones that try to commit fraud and we should obviously stop that. So I mean, there is a fear factor out there, and that's unfortunate, it was created over the past couple of years and I hope we can resolve it.

Thank you. Thank you, Mr. Chairman.

Mr. Regula. Mr. Wicker.

HOSPICE CARE IN RURAL AREAS

Mr. Wicker. Thank you, Mr. Chairman.

First of all, let me just say that I share Mr. Peterson's concern about the disparity between rural and urban reimbursement, and I hope to get back to that if I have more time.

My question is really related to that, but it deals with hospice care in rural areas. Now, there is currently a rule, and I spoke with the panel off the record before the hearing reconvened about whether that's statutory or regulatory. I do not know. But basically, the requirement is that no more than 20 percent of hospice care can be inpatient. The rest has to be outpatient or in-home.

The problem that we have in my neck of the woods is that the pool of persons desiring hospice is so much smaller than when you take 20 percent of that, it becomes impractical to have inpatient at all. And we have some people in Mississippi who would like to have a non-profit hospice facility that is 100 percent inpatient, on the theory that other hospice agencies have already taken care of the folks or are already taking care of the folks out in the home.

So I hope that you'll get back to me on what the regulation or whether this is a regulation or whether we can work with it, whether we must work with it from a statutory standpoint.

Do you see any reason why we should have this 80/20 rule, when there's no ability to take the 20 percent and actually have a viable inpatient hospice facility?

Ms. McMullan. As I understand it, the rule deals with the census of each organization. So it's 20 percent of the census needs to have inpatient care. My expectation is that in the original design of the hospice benefit, the anticipation of some people progressing to a stage of needing to be an inpatient was acknowledged.

So in order to continue to focus on the purpose of the hospice benefit, we keep people in the home as long as they are able to stay at home for the care--the majority was at-home care--but acknowledge that people sometimes progress to a stage where they need to be an inpatient. So that's my expectation of why the balance is 80-20. I can respond to you as to whether it's statutory or regulatory, and also give you some background as to why, when it was developed, they thought that was the right mix.

Mr. Wicker. Well, I'll tell you, the further concern that I have is that when the situation gets to the point where it's just not practical to have an inpatient facility at all, then the people who need to leave the home and go to a facility, go

into nursing homes or hospitals, that it's more expensive for the entire system. We could do better by the taxpayers by having more flexibility for inpatient. So I'm glad to know that we're going to work on that.

PAYMENT DISPARITIES IN RURAL AREAS

Now, let me get back to Mr. Peterson's point. It is a fact that a rural hospital in rural Pennsylvania or rural Mississippi performs a procedure and a hospital in an urban performs the same procedure in the same manner that the urban hospital is reimbursed at a higher rate, correct?

Ms. McMullan. It can happen. The law is not structured to say, if you're in a rural area you get paid less. But it certainly can happen, because of the way the payments are formulated.

Mr. Wicker. Because of the way the payments are formulated. It happens more often than not, does it not?

Ms. McMullan. The structure of the payment systems often relies on costs reported by each of the institutions. So if you look at the cost of an institution where the wages may be less, or other costs associated with providing care, that provides the base and from that base there could be a cost differential. But as I mentioned earlier, we'll be happy to talk to you about what we have done to try to deal with the issue of parity and payments. Congress has done a great deal as well to change, to try to even out, the payment systems.

Mr. Wicker. Well, okay, let me just say that if I were convinced it was based totally on actual, real costs, and it just cost more to perform these in an urban hospital than in a rural hospital, I would agree with that result. But I don't think that's what is happening. But what we are seeing, and I think this is what Congressman Peterson is crying out about, is we have hospitals in small communities, in rural areas, where people have not voted with their feet to leave. They want to be served in the small hospital. They come to the small hospital.

But the hospital cannot make it financially, bottom line, because they're not being reimbursed at a fair rate to treat those people. Even though there are people in the hospital there, they can't make it, bottom line, because it's not financially feasible. And that is a situation that we need to work together to address.

Thank you, Mr. Chairman.

Mr. Regula. Mr. Cunningham.

SUPPORTING HCFA'S EFFORTS TO SOLVE PROBLEMS

Mr. Cunningham. Thank you, Mr. Chairman.

You know, I want to tell you, the Secretary spoke very supportively of HCFA. I worked with the Secretary when he helped with Governor Engler in writing the Welfare Reform Act. I know the dedication he had to that, and the ability to solve problems. I think the first thing to recognize in any organization, group or person, is to recognize that there is a problem and I think that is recognized, both by yourself and by health care providers and this Committee on both sides of the aisle.

It's kind of like the IRS, when we went after the IRS, we felt that they were overburdensome and wielded power, because of their agency. It was an attitude problem, and now they're serving cookies and milk. That's quite a difference from IRS, when you walk in, they still may hammer you. But what a great opportunity we have. The Secretary told us about the understaffing that you have. He's basically living down there at HCFA, which I think is very noteworthy. The outdated systems that you have to work with, difficulties, the burdens that you have.

And even the current rules and regulations, that in many cases tie your hands from providing the health care that you and this Committee would like to see worked. What a great opportunity we have to fix that. There are some that want those tight rules. There are some that want Government control. For those I would say that it is counterproductive.

But I want to tell you that I've noticed a slight difference. I mean, we're getting phone calls back now. In February, I had a local physician asking for help dealing with a contractor that owed a bunch of money to him, and HCFA was very instrumental in that, I want you to know that, and I want to thank you for that.

But what I would like you to know is, this member at least is looking forward to helping you with the personnel, with the equipment, with all the things we can within the budget constraints that we have, but really going forward to making that happen.

NURSE ANESTHETIST RULE

I support limiting the amount of privacy, or not limiting privacy, but the amount of information that goes out on the web for privacy. Another thing I think is important that we look at, some of the issues have been covered, with the nursing emphasis, do you plan on letting that rule go forward on May 18th, which is due? They provide about 65 percent of all of those health care needs. I think many of us are supportive, especially since anesthesiology is about 50 percent more safe than it was in the past. Is there going to be any conflict with that?

Ms. McMullan. That rule, along with several others, was delayed in order for additional information to be considered, and it's still being considered. There has been a considerable amount of input on both sides of the question, and it's currently under consideration in the Office of the Secretary.

Mr. Cunningham. Does that mean yes or no in the 18th? Is it going to go beyond the 18th date before that is implemented? Or is that process going to take us beyond that period of time, do you think?

Ms. McMullan. It has not been the custom of the Secretary to take longer. But it is within his office to make the decision.

Mr. Cunningham. Okay. Well, I thank you. I think you've heard something. My father-in-law, I've got the greatest father-in-law in the world, had me go down to his doctor's office. He was just fuming mad on the paperwork and rules and regulations, just to get health care through the system with

all the rules. Many of us have concern about the latest. President Clinton, I think, I will give him credit, the health care issue he put up forward, he put it out in front. We feel that his way to deal with it was wrong. But at least he made it a focus so that there would be legitimate debate.

And in this, I think those rules and regulations at the last minute that he put forward, and many times it's tying your hands, like we talked about before, from providing that care. Members of this Committee will do everything we can to help you take the good, the bad and the ugly and separate them, and try and work with you. We're sympathetic with your problems. If you allow us to help you, we will. If there's politics involved, if there is gridlock involved, then there's going to be a problem.

But I think most of us are willing to bend over as much as we can, bend backwards and help in any way we can. I think you do have some monumental problems, not all self-generated. I want to thank you, we've already seen some responsiveness out of HCFA. We've got a long way to go.

Thank you, Mr. Chairman.

Mr. Regula. Thank you. Mr. Kennedy.

PARITY OF MENTAL HEALTH COVERAGE

Mr. Kennedy. Thank you, Mr. Chairman.

I'd like to address a really important issue that I had an opportunity to address with the Secretary, and that is parity insurance for mental health coverage. As you know, the mental health parity act of 1996 took a good step forward in recognizing discrimination exists in almost every health care policy. It's still legal to charge onerous co-pays for all services for mental illness and restrict the number of hospital days and outpatient visits, without regard to an individual's condition.

So it's estimated that 5 million Medicare beneficiaries have mental disorders, and many are severely disabled. Yet the Mental Health Parity Act does not apply to Medicare. So I'd like to ask you, there is a 50 percent co-pay for outpatient mental health, but only 20 percent for other health care patient physician visits. For inpatient days, there's a 190 day lifetime limit under Medicare for psychiatric hospital care.

What are you doing at HCFA to address the disparate coverage for other mental health services beyond medications in comparison to other physical health issues?

Ms. McMullan. Basically those are statutorily-required limits. Medicare was in its beginning, and remains, an acute care benefit program. The issue with mental health is caught up in that. But those are statutory benefit structure design issues.

Mr. Kennedy. Okay, so we have to pass a law making sure that there's parity, that's what you're saying?

Ms. McMullan. The underlying foundation of Medicare, in its root, is an acute care benefit. So to pay for care of both mental and physical chronic illness, the structure of the benefit needs to change.

Mr. Kennedy. I would love to have some input from your agency to what exactly we need to change in the law.

Ms. McMullan. I could provide that for you.

[The information follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

COVERAGE OF NEW ANTI-PSYCHOTIC MEDICATIONS

Mr. Kennedy. Because I'd like to push for that as long as I'm here in Congress.

I want to get to another issue, and that is in 1998, HCFA issued a letter to all State Medicaid directors on the use of newer anti-psychotic medications. The letter included an opinion from the NIMH director, Steve Hyman, detailing medical evidence regarding the benefit of newer anti-psychotic medications in treating illnesses such as schizophrenia. Unfortunately, since this letter was sent out, a number of States have attempted to limit access to these new, more effective medications through restricted formularies and policies that require Medicaid beneficiaries to first try on older medications which typically have severe side effects.

What is HCFA undertaking to assure that States, all States, comply with the spirit of the February 12, 1998 letter?

Ms. McMullan. I'll have to provide information for the record on that issue. I'm not familiar with it.

Mr. Kennedy. Okay, if you would, that would be great.

[The information follows:]

Anti-Psychotic Medications

On February 12, 1998, HCFA sent a letter to State Medicaid Directors providing information about recent advances in the treatment of schizophrenia. This letter was informational in nature and meant only to bring these advances in psychotropic medications to the attention of the States. To that end, we enclosed a letter from Dr. Steven E. Hyman of the National Institute of Mental Health that provided detailed information regarding advances in new psychotropic medications. As there is no requirement that States use these particular medications, our letter was designed to provide information for State consideration, not to establish new regulation or requirements.

MEDICAID EARLY AND PERIODIC SCREENING

Mr. Kennedy. Now I'd like to get to a question about the Medicaid Early and Periodic Screening and Diagnostic Treatment program. As you know, the Surgeon General in his report, as well as the National Academy of Sciences have issued reports emphasizing the importance of prevention and early detection in childhood to avoid serious emotional disturbances in children and youth. The science is very clear on this, that we can change the developmental trajectories of many youth with emotional problems.

Fortunately, we have a program that can assist with this. It's called the Medicaid Early Period and Screening Diagnostic Treatment Program, requiring States to provide screening and preventive services to children and treat conditions revealed by the screen. Federal law requires that the screen include

identification of developmental delays and mental health problems.

But unfortunately, the program is not fulfilling its promise. In one study, only 21 percent of providers in this Medicaid program, in the States, completed all 6 EPSDT checkup components. The percentage of children identified for mental health problems is much lower than expected from the Medicaid population. So HCFA does not require States to report the number of mental health and substance abuse screenings performed.

Can you tell me what concrete steps you are undertaking to ensure that States adequately screen children for mental health and behavioral health problems as required under current law?

Ms. McMullan. Again, I'll have to have that provided for the record. I'm familiar with the program, but not with the question that you've asked.

DECREASES IN THE RESEARCH BUDGET

Mr. Kennedy. Okay, I'll submit that for the record. And just draw your attention to it, because it is critically important, as you well understand. We can solve a lot of problems if we catch them early and identify and treat these kids.

Finally, I just want to get to an issue that has been addressed here with respect to choice issues for Medicare. In Rhode Island, we have a terrific advocacy group called Aging 2000. They provide important consumer information on Medicare benefits and coverage for seniors. This has been a very important program, especially since so many of our HMOs in the Medicare market in Rhode Island have pulled out and decided that Medicare is not profitable.

Aging 2000 has helped our senior population really adjust to all these changes within the HMO market. We're really excited about this, and we want to see it continue. But unfortunately, in the budget that's submitted, research and development is cut by \$80 million. So that's what this would come under. In particular, the budget for improving Medicare delivery is being cut, because of this.

Can you explain how important consumer choice programs and education programs will be and how important they are to be continued in the future and what we're going to do to make up for the cuts in the research and demonstration programs that are so vital to helping our Medicare population address all these changes in the Medicare system?

Ms. McMullan. To answer your question about the research budget, the research budget request for 2002 is at traditional levels. In 2001, it had been increased substantially due to a number of single-year activities and Congressional earmarks.

As far as getting information out to Medicare consumers about choices and changes in choice in their area, we have a substantial activity that is sponsored through the Health Care Financing Administration to make information available to individuals, both through the handbooks that we put at each place, the 1-800 number, and also through work with State organizations. I am familiar with Aging 2000, and it is a very noteworthy and capable group of people doing the work in Rhode

Island to make information available at a local level.

We do have partnerships that we sponsor. One of the workers in that group is a member of our advisory committee that helps us find direction for the program and target local areas. So we have, separate from our research activity, work going on to inform Medicare beneficiaries.

Mr. Kennedy. Well, I would appreciate any initiatives that you see yourself embarking on to address this baby boom senior boom population coming down the road and how we're going to have more programs like Aging 2000 out there, and what I can do to help you with Aging 2000. This has become a great model for consumer advocacy and I'd love to see it available in other States, to help my friends here, and their serving their constituents.

PREVENTIVE CARE BENEFITS

Finally, let me just ask you, when we had the Secretary, we talked about an ounce of prevention is worth a pound of cure. All of our health care system is geared toward sickness based care, taking care of people after they get sick, not covering any benefits that help keep people from getting sick. What steps are you taking to add preventive health benefits to Medicare?

Ms. McMullan. Again, the benefit structure of Medicare is basically an acute care benefit program. Congress has added in recent years some preventive health benefits including flu shots, mammograms, and cancer screening benefits. Basically, it would require a benefit structure change, which requires legislation.

Mr. Kennedy. All right. Like the mental health stuff, would you get me what I would need to do as a legislator to try to make those changes statutorily?

Ms. McMullan. Yes, we'd be happy to do that.

NURSE ANESTHETIST RULE

Mr. Kennedy. And the HCFA final rule on anesthesia care becomes final on May 18th as scheduled. Is it going to be finalized--did you ask that already, Mr. Chairman?

Mr. Regula. Mr. Jackson's deferred.

Mr. Kennedy. Well, I'll submit this question for the record, and thank you for your kind attention.

Mr. Regula. Mr. Jackson.

PROPOSED LAW USER FEES

Mr. Jackson. Thank you, Mr. Chairman, and thank you, Mr. Kennedy.

I have a number of questions, Mr. Chairman, that in the interest of time that I'm going to submit for the record. I have a number of meetings that are going to be scheduled in the future with the Administrator and with the Secretary.

I have a question about user fees. I notice that your budget assumes \$115 million in user fees to offset the \$109 million increase in HCFA's discretionary budget. I'm wondering, is there any way the providers will end up passing this \$1.50

user fee on to consumers in the form of less care?

Ms. McMullan. I can't imagine that would occur. We can certainly look and see if we see any sorts of patterns that would indicate that. We just don't expect that that would occur.

Mr. Jackson. I'm very interested in your analysis of that, because every indication is that whenever the discretionary budget decreases, that somehow it ends up getting passed on to the consumer, either in the form of less care or in the case of some consumers, in the form of increased costs.

NURSING HOME INSPECTIONS

Let me ask one last question, if I might. With the number of people getting older and living longer and more people working and not being able to take care of their patients, I would imagine more elderly would be going into nursing homes. I'm concerned that your budget did not include funds for nursing home inspections. How are you planning on making up for the shortfall?

Ms. McMullan. The budget does include money for nursing home inspections.

Mr. Jackson. One second, please.

Again, Mr. Chairman, in the interest of time, I'm going to submit that question for the record with our backup information, and we'll see if we can reconcile the two. If you could be so kind, Madam Administrator, as to respond to my questions in the record, I would be greatly appreciative.

Thank you, Mr. Chairman.

Mr. Regula. Thank you. Mr. Kennedy, did you have anything else?

NURSE ANESTHETIST RULE

Mr. Kennedy. Thank you, Mr. Chairman. I do. On the anesthesia, there's a rule coming out May 18th. Are you going to go ahead with that, for nurse anesthetists?

Ms. McMullan. That rule is in the Office of the Secretary. They are looking at the comments they've received and will make a decision.

Mr. Kennedy. Thank you, Mr. Chairman.

1-800 TELEPHONE SERVICE

Mr. Regula. I think we're going to have a vote around 11:30. I have some questions, and perhaps we can finish before we have to go and vote.

This is a practical question. I noticed you have an 800 number for people in the state booklets. When they call that 800 number, and I am going to try it out myself, do they have to go through the whole automated series of press 1, 2, 3, 4, 5 or do they get a live person?

Ms. McMullan. The 1-800 number operates 24 hours a day. Eight hours a day, it is staffed by customer service representatives. The caller does go into an automated response unit, but they can immediately go to a customer service person if they so choose.

Mr. Regula. So they have that option?

Ms. McMullan. During 8:00 to 4:30 local time.

Mr. Regula. Okay. And during the other times you'd get what, a voice response or canned response?

Ms. McMullan. There are a couple of options. They can leave their name and address if they want a publication, or they can listen to frequently asked questions to get the answers.

Mr. Regula. But I think the important thing is that during working hours you can get to a voice without going through the whole automated series.

Ms. McMullan. Yes, you can get to a real person.

NURSING STAFF SHORTAGES

Mr. Regula. I was talking with some people this morning that support the health care programs, nurses, nurse anesthetists, etc., and they said that we already have shortages of personnel in these professions, and that it will be exacerbated over time. What's your evaluation of that? Is adequate staffing for physical therapists, etc. going to be a problem? There's a whole range of support services that are part of the medical care system.

Ms. McMullan. I'm very familiar with the nursing shortage issue. That has come up recently, and it's something that the Department is looking at across all its programs to see what we can do to deal with some of the issues around nursing shortages. I'm not as familiar with what the future pattern of other support services is, but I can certainly provide that information, any information we have within the Department.

[The information follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Mr. Regula. I don't know whether it would be your agency or another agency that would have responsibility to sort of look out into the future and try to anticipate problems. Is that a proper role for HCFA?

Ms. McMullan. We look at it in relationship to our population and our programs. But the primary responsibility is in HRSA.

Mr. Williams. Dr. Duke was here yesterday testifying for the Health Resources and Services Administration, and the health professions program in HRSA does keep statistics and does research on the availability of various health professionals over time. And the nursing shortage is something they have documented, and as we testified yesterday, the budget does include some additional resources there.

Mr. Regula. Would HCFA be privy to information that would be indicative of this possibility and pass it on to HRSA?

Mr. Williams. There's a lot of communication inside the Department. I'm sure HRSA passes its information to HCFA. If HCFA has independent information, I'm sure they would share it. But that may not be part of its normal research function, and wouldn't necessarily be a central issue for them. But they certainly have access to the information that the Health Resources and Services Administration would develop on these

issues.

MEDICARE & YOU HANDBOOK

Mr. Regula. How often is this booklet revised?

Ms. McMullan. The handbook is updated once a year.

Mr. Regula. Do you base revisions on sort of a focus group approach, where you actually get a group of seniors and give them a chance to have input as to whether this is something they find usable?

Ms. McMullan. Yes, we do.

Mr. Regula. User friendly, I guess is the right word.

Ms. McMullan. We do a couple of things. One, if there have been any statutory changes, as an example, in 2002 there's a statutory provision that goes into effect that affects enrollment in Medicare+Choice plans, those kinds of changes are reflected. So we look at any statutory changes that need to be explained.

We go out and test with people who have received the book to see what they understood, and what they didn't. We do low-literacy review because our population is less literate, and also has some reading impairment. We review it to make sure that we're explaining it as simply and as clearly as possible to that audience.

Mr. Regula. Do you do this in other languages at all?

Ms. McMullan. We do it in Spanish and we do some of it in Chinese. And in areas where other languages are frequently spoken, our regional office staff will take elements of it and convert it into languages that are found in the areas they serve.

Mr. Regula. Do you get many calls? I notice it says if you don't understand some thing, you can call this 800 number. Do you get a lot of calls?

Ms. McMullan. We are projecting 5 million calls next year.

Mr. Regula. And that information then will be used in part to revise future editions----

Ms. McMullan. Yes it will.

Mr. Regula [continuing]. To address those most frequently asked questions.

Ms. McMullan. Yes. And we also use it to revise our website. We have a very good website, I mentioned it in my testimony, www.Medicare.gov. It's a very comprehensive website targeted to people with Medicare, who are actually receiving the services. It explains the benefits, explains the choice of Medicare+Choice plans, nursing homes. For people on dialysis, there's a dialysis facility comparison. There's a lot of very useful information.

PROVIDER REIMBURSEMENT

Mr. Regula. How do you arrive at the amount you reimburse? It seems that each different procedure has a reimbursement number. The complaint I hear from the medical profession is that these numbers are totally inadequate for the service that they're expected to provide. My question is, how do you arrive at these numbers?

Ms. McMullan. There are nine different payment

systems, largely dictated by statute, as are the formulas that we use to derive the payment systems and the structure of the payment systems. But in any one particular case, or in all of them, actually, we'd be glad to give you a high-level overview of how the payments are formulated and on what basis.

Mr. Regula. Well, as I understand it, the statute sets the formula, but it doesn't set amounts. For example, let's take a heart bypass. I don't know what the reimbursement is on that, but its set internally, is it not?

Ms. McMullan. To use inpatient care as an example, the cost of providing the care is provided by the hospital, the wages are provided by the hospitals, and other factors that are used to make adjustments, such as disproportionate share of the poor. That all goes into a statutorily-mandated formula, often that needs to be budget neutral, so there are redistributive effects within the formula.

In the end, we publish a rate. We're actually in the rate publishing season now. Our rate regulations are coming out, where we publish exactly what the prices are for each of the different categories. The payment systems also are paid by categories. The one that you mentioned would be the inpatient hospital, which is based on a diagnostic-related group, so we'd pay by the diagnosis.

But again, we'd be happy to explain any of them in particular. But there are nine different payment systems with different methods to set the payments.

Mr. Regula. So a physician that provides a certain service in rural America would perhaps not be reimbursed as much as somebody in the city of New York for a similar procedure?

Ms. McMullan. That's correct, because there are geographic factors in the physician fee schedule.

PHYSICIANS ACCEPTING ASSIGNMENT

Mr. Regula. At one time, was it not the practice that the physician had to be willing to accept whatever the Medicare reimbursement was, that they were not allowed to negotiate an extra amount with the patient?

Ms. McMullan. In Medicare, physicians can accept assignment, in which case they accept a Medicare payment. Physicians do not have to accept assignment. They can charge, but then there are balance billing limits on how much they can charge.

A physician can offer any service to a beneficiary. Between the beneficiary and him or herself, they can agree to pay outside of Medicare. The beneficiary does not have to bill Medicare if they do not choose to.

There is also a very particular provision that I think was part of BBA, where physicians can privately contract with individuals. But that's a much more structured activity.

Mr. Regula. When you say accept assignment, is that on a case by case basis, or is it the case that if a physician is delivering Medicare services, and accepts assignments, that would preclude them from negotiating extra amounts with patients?

Ms. McMullan. If they participate in Medicare and accept assignments, they do it for all Medicare beneficiaries.

Mr. Regula. So they're locked in. That created some unhappiness among the medical practitioners and currently the system is still in place.

Ms. McMullan. A significant proportion of physicians do participate.

Mr. Kennedy. Mr. Chairman?

Mr. Regula. Yes, I'll yield.

PAYMENT DENIAL

Mr. Kennedy. How do you track denial of care? Do you have any kind of mechanism, when the Chairman was asking about the phone number, is there any measure or complaints about insurance companies denying care, something like that?

Ms. McMullan. Are you talking about denying care or denying payment?

Mr. Kennedy. Yes, denying payment.

Ms. McMullan. We actually have numbers of payment denial. So when claims are processed through, we know the percentage of claims that are paid and the percentage of claims that are denied. As far as denying care, we would not have that information. If care wasn't provided, we wouldn't be billed, so we wouldn't know what care wasn't provided. We have no way of tracking that. But we do keep statistics on the number of claims that are processed without question and the number that are denied.

Mr. Kennedy. I'm talking about like the Patients' Bill of Rights, trying to establish that people are not going to get the care, that they are insured for, denied. Do we have any idea what those figures are?

Ms. McMullan. In Medicare in general, all of the elements of the patient's bill of rights exist[s] within the Medicare program. If someone believes that they have been denied access to care, they can make a complaint and we can investigate that complaint.

Mr. Kennedy. And how many complaints are made in a year?

Ms. McMullan. I'll have to provide that to you for the record.

Mr. Kennedy. Would you? That would be, I think, interesting for the whole Committee, too. How many would you guess? A thousand?

Ms. McMullan. I really have no idea.

Mr. Kennedy. No, but I mean, it's a big difference if it's less than a thousand or over 50,000. You've got a population, you know how any people are covering.

Mr. Regula. Well, you can put it in the record.

Mr. Kennedy. I have a feeling, Mr. Chairman, that it's less than 1,000, which is pretty dramatic illustration of the fact that there isn't an adequate tracking, people don't have an ability to really complain and see their complaints addressed. I'll look forward to the information.

[The information follows:]

Complaints of Denial of Care

HCFA's data on beneficiary complaints about denial of care come from two different sources: the independent review entity

(IRE) and the peer review organizations (PROs).

Managed care plans review the initial denial given to a managed care enrollee. If the plan upholds its denial, the case is forwarded to HCFA's IRE for reconsideration. Although HCFA does not collect data on the number of appeals submitted directly to managed care plans, we can extrapolate from the number of cases processed by the IRE that, in calendar year 2000, managed care organizations received about 52,000 appeals of initial care denials.

In the last year, the PROs received an estimated 110 beneficiary complaints (3.3 per million beneficiaries) involving access to care issues and 3,880 beneficiary appeals (114 per million beneficiaries) involving additional days stay in the hospital. The PROs also received about 380 Emergency Medical Treatment and Labor Act (EMTALA) complaints; however these reflect care delivered to all individuals, not just Medicare beneficiaries. These figures reflect the total number of complaints received by the PROs; typically, only a small fraction are confirmed as actual instances of inappropriate denial of needed care.

PAYMENT DISPARITIES IN RURAL AREAS

Mr. Regula. Mr. Peterson was talking about the problems in rural areas. One of the problems in my area is you have a community of say, 25,000, and it's treated as rural and yet, the city 30 miles away is treated as urban and therefore get substantially more reimbursement for nurses. What this does, as a practical matter, is prices the smaller hospital out of the market, because the nurses in the smaller hospital can easily drive to the larger urban area and get the extra money.

Is that a problem generally? I guess that would be something that would require a statutory change in the formula.

Ms. McMullan. To answer your second question first, I don't know whether or not that's part of the pattern of nursing issues that we're seeing, that nurses are going where they can to get more money. You can understand that that's not an unusual behavior. But as far as the payments, the differential payments are rooted in the costs and the wages that are paid in those areas and their historic formulas. So there have, as I said earlier, been some adjustments to those formulas to account for the rural differential. And we would be happy to provide information regarding the kinds of issues, what has been changed, what we understand about the continuing rural and urban disparities and what we're doing about that.

Mr. Regula. But you cannot arbitrarily make adjustments internally, as I understand it. You're bound by the statutory formula.

Ms. McMullan. We are.

Mr. Regula. I've talked to the Chairman of Ways and Means, and they're looking at it.

Mr. Peterson, do you have some additional questions?

ADMINISTRATIVE BURDEN

Mr. Peterson. Yes. Back to the nursing issue, nurses are fleeing the bedside care, where we need them, in my view.

They've always had the problem of weekends and seven days a week care, swing shifts. It's not been an 8:00 to 5:00 job. So whenever there's a chance that a nurse can do an 8:00 to 5:00 job, they take that.

But what I'm told by young nurses who have just practiced a few years, they didn't go to school to be a nurse, to be a clerk. And the maze of paperwork that an RN does in almost any setting is driving them out of--they just don't want to be clerks. You have put such a paperwork load on nursing that nobody wants to be a nurse. And I guess in the bigger picture, is there any thought process at the leadership of HCFA to simplify this complicated, convoluted system that is more complex than the IRS?

Ms. McMullan. We are indeed looking at the issue--at the kinds of assessment instruments that we are asking, that nurses are customarily asked to complete, as part of the payment system--to see what we can do to streamline that process. We're very conscious of the complaint and the criticism.

There is, in all things, a balance to be struck on those assessment instruments. I understand the complexity of the individual's care, so that the payment can be adjusted to pay fairly for the complexity of the care and the burden that it's putting on the professional at the bedside. So we are looking at that as part of the overall Department review of what we can do about the nursing shortage and what barriers we can remove--the things that are under our discretion.

OUTCOME AND ASSESSMENT INFORMATION SET

Mr. Peterson. Well, as a practical business person, I would suggest that you take those who are designing those forms and let them go work in a hospital for a while at bedside care. They need to know what bedside care is about. I guess that's the problem I really have. And this is not personal.

But the system of HCFA is so removed from patient care that this theoretical paperwork maze you're continuing to build on, and I'll just take OASIS. I had to fill out an OASIS form two years ago. Ninety-some questions. If I had left home health care for a month and came back into it again, I would have to answer those 92 questions again. If I left for another month and came back into the system, in most systems, once you put the data in there, it's once. You don't do it every time. You force home health care agencies to fill out the OASIS form every time they re-enter a person into home care. That's not how most business is done.

People are scared to death of HIPAA. Hospitals and agencies are scared to death of what's going to come down in that paperwork, because they can't handle the paperwork they have and provide care. I guess, if I can impress on you, those who are designing these systems, and I know it's all done about quality and control and outcome, but send them to the bedside where care is given so they understand the role of nurses and other health care providers in providing health care. Then design a system that doesn't remove the health care provider from taking care of the patient. That's really what's happening out there.

And I'll go back into the old DRG system. We were working

on a bill in Pennsylvania when I was a state senator. We had a book of the DRGs, a doctor, a family physician could charge in his office. And not that the list was huge, page after page, hundreds of pages, there was 10 levels of care on every DRG. And I don't understand that, because it seems to me it ought to be that you could have three levels of care, you could have a simple visit, a medium visit or a complex visit. Not ten.

But I mean, your whole system has people, and the providers today are afraid if they mark the wrong one they're going to be jailed because they defrauded the system. If it's simple, medium, complex, that's pretty simple. But when you give ten levels of care, then it can be challenged.

So the whole maze of paperwork, in my view, is the biggest problem that's driving people out of the health care system. They just can't handle it.

Ms. McMullan. We are looking at that. We're conscious of the issue. It is one of the barriers, and one of the balances to be struck is the precision of the information and its importance to payment, and then the burden and its importance to access to care. And we do understand that dynamic.

NURSING HOME INSPECTIONS

Mr. Peterson. Earlier someone mentioned nursing home visits. There's no shortage of nursing home inspections. Check with your nursing homes.

But the good homes are inspected maybe 10 times in a year, and the bad homes--you know. A good system goes to the homes that have problems. If you have an A plus home that provides quality care, you don't over-inspect them. You take your resources and you go and you take all of the, you should somehow work out a system that all of the providers, or those that are assessing nursing homes, develop--I mean, nursing homes are the most over-inspected place we have, and yet we still have problems, because there are a few bad ones. Most of them are pretty good places of care.

But we over-inspect the good ones and under-inspect the bad ones, in my view. That's it. Because we treat them all alike. In the real world, if you're a problem case, you get a lot of attention. If you're listed as A plus care, you're going to get very little attention, because we know you give good care. And I think the system doesn't do that.

And in response to the person, I don't know whether that answers their question, but that's my view of nursing home inspections.

Mr. Jackson. Would the gentleman yield?

Mr. Peterson. Sure.

STATE SURVEY AND CERTIFICATION BUDGET

Mr. Jackson. I thank the gentleman for yielding. I looked at my question again, and maybe I didn't present it correctly the first time. What I asked specifically was that the number of people who are getting older and living longer is increasing. And therefore, more people will be entering into nursing homes.

The end result of your budget, you didn't actually zero it

out, but because the increase, because there are no significant increases in home inspections, there's going to be a shortfall. So what I asked specifically was about the shortfall. I may not have phrased that correctly, but my sense was that because the population is aging, we have to assume that more people are moving to nursing homes.

But the budget, as I have had it reclarified for me, suggests that the number is not necessarily increased, the number for inspections is not keeping up with the amount of people who will be entering the homes. So we'll have to have more nursing homes, but obviously a shortfall in inspectors.

Ms. McMullan. The budget line that you're talking about actually has increased substantially in previous years, and it's at a stabilized level in the 2002 budget. We're not expecting substantial increases in the census of nursing homes. The population is aging, but the bulge is coming more in 2010 and after.

Mr. Jackson. I thank the gentleman for yielding.

ADMINISTRATIVE BURDEN

Mr. Peterson. You're welcome.

Back to the OASIS issue. Is it true that you require the OASIS documentation on a home health care agency, even if it's not a Medicare patient?

Ms. McMullan. Yes we do.

Mr. Peterson. Why?

Ms. McMullan. I believe that we can provide this for the record.

[The information follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Ms. McMullan. They're looking at the census to make sure that each patient has a sufficient assessment and an evaluation of what their health care needs are. But I will be happy to provide that for the record. I don't know the----

Mr. Peterson. But that's the perfect example of a bureaucratic structure deciding they are the god of health care. Did Congress give you the role of being the goddess of health care? Not you personally. Please don't take this personally. But I mean, your agency, the goddess of health care, and that you're to protect people that have nothing to do with Medicare, that's your job?

I mean, I guess that's the reach of HCFA that I have real trouble with. And to force them, if you were in and out of the system eight times in a year, you're going to do that eight times. That's just bad public policy.

Ms. McMullan. We can look at your issue around OASIS. Indeed, anyone receiving care in a Medicare and Medicaid--certified facility is under the auspices of our survey and certification program.

Mr. Peterson. So you are the goddess of health care?

Ms. McMullan. I've been called a lot of things----

Mr. Peterson. Not you personally. [Laughter.]

ASSISTED LIVING FACILITY SURVEYS

Mr. Regula. You've got a new title this morning.

Along this line of questioning, on assisted living, which I understand could be Medicaid reimbursed, do you conduct inspections?

Ms. McMullan. Assisted living centers are not subject to the survey and certification rules. They're outside----

Mr. Regula. Even though they're getting Medicaid reimbursement in some cases?

Ms. McMullan. There may be State inspections, but they're not part of the Federal survey and certification system.

Mr. Regula. Okay. I think Mrs. Northup is next, and then we'll go to you, Mr. Kennedy.

HMO REIMBURSEMENT

Mrs. Northup. I had a Committee meeting across the hall, so I don't think this is entirely repetitious. I asked you originally about the SCHIP program and do we want to pull everybody into public health or do we want to empower the private sector. I'd like to continue that in a different area, and that is with the Medicare+ Choice plan and the problems we've had with their reimbursement rates.

It's my understanding that there is a reimbursement rate, and then there are risk, adjustors, so that if one company happens to pick up a number of high cost individuals or people that are high risk, and another company tends to have low risk or a more well population, that there are risk adjusters to transfer money from one to the other. In the course of doing that, the claim has been made, and I think fairly substantiated, that HCFA's way was also to sort of suck out another 5 percent and keep it for themselves, as they moved this money around.

Because of that, the HMOs that have wanted to serve our seniors and provide them with some choices have left the field. I wondered if you would comment on this, and clarify anything that you think was mistaken in my impression.

Ms. McMullan. We are indeed implementing risk adjustors, in order to more appropriately pay for more complex cases. I am not aware of any part of the payment formula that gives any money back to the trust fund.

Mrs. Northup. Well, I think the question is, wasn't the amount paid the HMO a proportion of what the average Medicare--
--

Ms. McMullan. In the previous payment system, we paid 95 percent of what was paid for fee-for-service Medicare. That payment system has changed. By statute, we no longer use that.

Mrs. Northup. And what does the statute say? Doesn't the statute say to provide for risk adjustments and the Administrator has taken that to give them license to withdraw money out of that system?

Ms. McMullan. To my knowledge, there's no opportunity to withdraw money. I can get you a simple explanation of the current payment structure for how we pay Medicare+Choice or capitated plans.

Mrs. Northup. And when you pay capitated plans, you pay a

percentage of what the fee for service is, and then apply risk adjustors, is that correct?

Ms. McMullan. The current payment system is based in part on the previous system. This is just a risk adjustment. The payment formula for Medicare+Choice plans--let me see if I can give this to you easily. It's a very complex system.

Mrs. Northup. Oh, I know it's complex.

Ms. McMullan. But it's not based on a percentage of the fee-for-service system any longer. It's a much different structure.

BBA CHANGES TO PAYMENT STRUCTURE

Mrs. Northup. And that was part of which law, the Balanced Budget Amendment?

Ms. McMullan. Of 1997.

Mrs. Northup. And the Balanced Budget Amendment of 1997, what did it say about the payment structure?

Ms. McMullan. It changed the way we formulate the payment structure. It said floor payments and a percentage increase in the payments were planned. And it added the requirement for a risk adjustment, so that we could pay for more complex cases.

Mrs. Northup. Would you say that in reading that, that it's impossible to conclude that what Congress intended was to make sure that there wasn't cherry picking, but not to reduce further the overall amount that we paid for the private choice plans?

Ms. McMullan. As we understand it, the purpose of the change was to pay correctly, to pay for the level----

COMPARISON BETWEEN CAPITATED RATES AND FEE-FOR-SERVICE PAYMENTS

Mrs. Northup. Absolutely. It's to pay correctly. And if we paid 95 percent of what the traditional fee for service was, we would still save money.

But by allowing risk adjustors, in other words, if one company takes 100 people that have cancer and another company takes 100 healthy people, to pay them the same per person makes no sense. So it is the claim of many of us that the risk adjustor was added in order to try to say, based on the high cost to individuals to transfer money between plans, not to use that as a basis to pull money out. What's the current percentage we pay these plans compared to the fee for service?

Ms. McMullan. Congress asked for us to do a report on what, on a county-by-county basis, we pay in the Medicare+Choice capitated rates and the equivalent fee-for-service amount. I believe that report was due in March. We are now targeted to give the first report in June. Our actuaries are developing that, so I can't answer that question until we have that data.

Some of what you may be referring to is that there are budget neutrality provisions in the BBA.

Mrs. Northup. Well, and they're all to come out of the capitated plans?

Ms. McMullan. As in most systems, budget neutrality is within the----

Mrs. Northup. The whole plan?

Ms. McMullan. The system, yes.

Mrs. Northup. Well, I'm sorry, then that wouldn't explain it. If you're going to have a budget neutral plan, and the capitated plans take the same hit as the fee for service run by HCFA does, then they'd all be reduced proportionately. That doesn't explain for a bigger variance.

I believe that the figures I've seen show that we're now down in the 80 percent capitated plans to get--no? Is that incorrect?

Ms. McMullan. But we'll be happy to provide that information.

[The information follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Mrs. Northup. Mr. Chairman, on the record I want to say that I believe that considering the cost of administering the program, we should do everything we can to allow individuals that want to be in private health insurance in their senior years, and want to have choice, choice for plans similar to what those of us that currently have insurance have, that we should encourage that, especially when every person that chooses that also saves taxpayers dollars. Thank you.

Mr. Regula. Mr. Kennedy.

OVER-REGULATION OF HOSPICE CARE

Mr. Kennedy. Thank you. I know we have a vote on, but I just wanted to have you provide for me what you're doing with regard to the hospice programs. I get complaints from my hospice care providers that it's the over-regulation is just counterproductive when you're dealing with someone who's dying, who is terminally ill, that these Medicare regulations that they have to adhere to are not sensitive to the unique situation that these providers are in, because they're really there to help assist someone in dying, and yet they're being evaluated as if they're trying to keep them well, when that's not the possibility.

I think the pain management issues are a big problem for them, too, in terms of what they're permitted to prescribe in terms of pain management. I would just like to have your agency provide me what you're trying to do to help not get doctors and so forth in trouble for doing what they need to do to help people who are terminally ill.

Ms. McMullan. We'll be glad to provide that.

[The information follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Mr. Kennedy. Thank you.

COST EFFECTIVENESS OF PREVENTIVE MEDICINE

Mr. Regula. Just one last question. Based on your experience, what preventive techniques, and we've done it with flu shots and cancer screenings, but are there other things

that could be 100 percent reimbursed that would actually reduce overall costs? That would be cost effective in terms of preventive medicine? Do you have examples that you could suggest to us? I realize this would take statutory change, but are there ideas that your agency has?

Ms. McMullan. In the Department, there are ideas on what preventive care would best advantage the population. We'll be glad to provide that to you. There are other parts in the Department that focus their energies on looking at these issues, for example, the Centers for Disease Control and others. We'll be happy to provide that to you, and also provide the things that the Medicare program has looked at directly.

Mr. Regula. I know in the case of flu shots, people from HHS said they felt it was very cost effective because it reduced respiratory illnesses, it reduced early deaths, and for a variety of other reasons. For the cost involved in providing the shots it was a very good program. I just wondered if there were other opportunities.

Ms. McMullan. I'm sure that there are, and we'll provide those to you.

[The information follows:]

Suggestions for Additional Preventive Benefits

Both the Balanced Budget Act of 1997 (BBA) and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) added significant new preventive benefits to the Medicare benefit package.

We closely follow the work of the U.S. Preventive Services Task Force (an independent entity supported by the Agency for Healthcare Research and Quality), which reviews and evaluates evidence for clinical preventive services. This work should become even more relevant to Medicare in the future, since BIPA directed the Task Force to conduct a series of studies to identify preventive interventions of particular value to older Americans.

We would be happy to work with you as Congress considers adding new preventive benefits to the Medicare program.

Mr. Regula. I think that concludes our hearing. We do have a vote on the budget resolution rule. Thank you for coming. It's been a productive hearing and we appreciate your patience.

The subcommittee is adjourned.

[The following questions were submitted to be answered for the record:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Tuesday, May 15, 2001.

ADMINISTRATION FOR CHILDREN AND FAMILIES

WITNESSES

DIANN DAWSON, ACTING PRINCIPAL DEPUTY ASSISTANT SECRETARY

DENNIS P. WILLIAMS, DEPUTY ASSISTANT SECRETARY, OFFICE OF BUDGET,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Regula. Well, we will get the committee hearing started. We are happy to welcome you, Mrs. Dawson, and you are going to tell us why we should continue to support the Administration for Children and Families and about all the good things they do, and we will be very persuaded when you are finished. Right?

Ms. Dawson. Yes.

Mr. Regula. Okay. We will put your entire statement in the record, and you can summarize as you choose.

Ms. Dawson. Thank you, Mr. Chairman.

Mr. Chairman and Members of the Committee, I am pleased to present the President's budget request for the Administration for Children and Families for fiscal year 2002. I am accompanied by Dennis Williams, Deputy Assistant Secretary for Management and Budget.

Mr. Regula. We have gotten to know him.

Ms. Dawson. The fiscal year 2002 budget for the Administration for Children and Families is \$44.4 billion, of which \$25 billion is being requested in new budget authority. The remaining \$19.5 billion has been appropriated through the Personal Responsibility and Work Opportunities Reconciliation Act of 1996.

This budget request for ACF is 2.9 percent above the fiscal year 2001 enacted level and reflects the President's commitment to a balanced fiscal framework while, at the same time, increasing support for America's children and families. Within this context, I would like to share some highlights.

In fiscal year 2002, the budget for the Administration for Children and Families includes \$12.6 billion in discretionary funds and \$31.8 billion in entitlement funds.

In addition to seeking continued funding for a wide range of programs serving some of the Nation's most vulnerable populations, including Low Income Home Energy Assistance, the Community Services Block Grant, programs for persons with developmental disabilities and services for refugees, the ACF budget includes a number of targeted programmatic increases and new initiatives aimed at improving the quality of life of our Nation's families, as well as increasing support for the charitable organizations that can make such a difference in people's lives.

I would like to turn to a few key programmatic initiatives in our fiscal year 2002 request.

In the area of child care, the fiscal year 2002 request proposes to increase the discretionary funds available for the Child Care and Development Block Grant by \$200 million for a total FY 2002 level of \$2.2 billion. The President's budget includes a \$400 million set-aside to provide parents with certificates to obtain after-school child care with a high quality education focus for eligible children up to 19 years of age. This would help low-income working parents pay for the cost of care to children especially vulnerable to crime and at-risk behavior when left unsupervised after school.

Additionally, the FY 2002 budget includes a \$150 million increase in preappropriated child care entitlement funds.

We are also seeking a \$60 million increase in funding for

the Independent Living Program within the Foster Care and Adoption Assistance entitlement. This funding is intended to provide vouchers worth up to \$5,000 for education and training to help young people who age out of foster care to develop skills to lead independent and productive lives.

The budget includes \$33 million for community-based adult-supervised group homes for teenage mothers and their children. The homes would provide safe, stable nurturing environments for teenage mothers and their children who cannot live with their own families because of abuse, neglect or other extenuating circumstances.

Promoting responsible fatherhood is part of our budget. Helping young mothers is an important part of programs to assist America's families, but it is also important that we recognize the critical role that fathers play in the lives of their families. A new \$64 million program would be authorized to strengthen the role of fathers in families and marriage. The program would provide competitive grants to faith-based and community organizations, as well as fund projects of national significance that focus on public education and awareness, the use of mass media campaigns, the development of best practices, research and technical assistance.

The President has been a leader in recognizing the important role that charitable organizations play in delivering services to the public. And our budget includes a newly proposed Compassion Capital Fund. The fund would provide start-up capital and operating funds totaling \$89 million in FY 2002 to support qualified charitable organizations that wish to expand or emulate model social programs. This funding would build on the efforts of charitable organizations by supporting the creation of public-private partnerships in addressing the needs of low-income families.

In addition, these funds would be used to promote research on best practices among charitable organizations.

Further, to encourage States to create State tax credits for contributions to designated charities, this budget proposes to allow States to use the Federal Temporary Assistance for Needy Families, TANF program, funds to offset revenue losses from such contributions.

Finally, our budget takes a number of steps to help protect our most vulnerable and at-risk children and to help them live safe and productive lives. First, we are proposing a \$200 million increase for the Promoting Safe and Stable Families program, which supports State and Tribal child welfare agencies in carrying out family preservation, family support and adoption assistance services. These additional funds will be used to help serve the best interests of children by either keeping them with their biological families, when it is safe and appropriate, or expediting adoptive placements when it is not.

Second, we are proposing to create a new discretionary initiative that will provide \$67 million within the Promoting Safe and Stable Families program to assist children of prisoners. This additional new funding would go to States to fund competitive grants to faith-based and community-based groups to mentor the children of prisoners and probationers.

I would also like to highlight the fiscal year 2002 budget request for Head Start of \$6.3 billion; this is an increase of

\$125 million. This will support all Head Start programs in maintaining the current level of services, while efforts are undertaken to improve the program's focus on child and family literacy in order to better prepare children for school.

The fiscal year 2002 request for Federal Administration is \$172 million, plus an additional \$3 million for the Department's Center for Faith-Based and Community Initiatives for a total of \$175 million, an increase of \$11 million or 4.9 percent over the fiscal year 2001 enacted level. This level is expected to fund 1,547 full-time equivalent staff. This request would provide sufficient funds for pay raises and additional support for ongoing implementation of the child welfare monitoring initiative, as well as provide 15 new FTEs needed to support the Department's Faith-Based Center that was established in accordance with the President's executive order.

In conclusion, I would like to emphasize that ACF is committed to results, to the measurement of results, and to joint work with our partners. Under the requirements of the Government Performance and Results Act and within the framework of the departmental goals, ACF has developed strategic goals, performance standards and measures. The priorities reflected in the FY 2002 budget are in support of the strategic goals that are contained in our performance plan, that is, to increase economic independence and productivity for families; to improve healthy development, safety and well-being of children and youth; to increase the health and prosperity of communities and tribes; and to build a results-oriented organization.

We look forward to working with Congress on achieving these goals.

Thank you, Mr. Chairman, and I will be happy to answer any questions that you may have or the committee may have at this time.

Mr. Regula. We will go to Mr. Hoyer.

ADMINISTRATIVE COSTS

Do you have any idea what percent of your budget is spent on administration versus actually directly benefiting the children and families?

Ms. Dawson. I think our budget is roughly about .4 percent, the Federal Administration part of our budget.

PROGRAM EVALUATION

Mr. Regula. Do you do any follow-up? Is there any system whereby these children that have received benefits in one way or another are evaluated, as to whether there is a long-term impact? Is there any follow-up evaluation of the program?

Ms. Dawson. We have over 60 programs in ACF, and certainly in many of our programs we have research studies; we conduct evaluations.

To give you some examples, we do a number of research evaluations in the area of child care, in our welfare reform programs, and in our Head Start programs. All of these studies of various kinds are either to demonstrate impacts on children and families or are to evaluate how well programs are operating and how successful the effects of the programs have been.

EARLY LEARNING

Mr. Regula. Well, the President is proposing an Early Reading First program, and I am not sure that I know the difference between--or understand the difference between that and Head Start in terms of the objectives.

Ms. Dawson. As I understand the Early Reading First program, which is not in the ACF, that program would actually be administered and funded by the Department of Education.

Mr. Regula. Yes.

Ms. Dawson. The Head Start program, which is certainly one of our major programs, is a program that is comprehensive and focuses on early learning and focuses on getting children ready for school. The Head Start program has many components, which include the educational component, as well as social services, health, nutrition, all the aspects that go to supporting children's early learning, as well as to supporting families in helping their children to learn.

So our Head Start program does contain an educational component that focuses on literacy, on learning, on helping children to increase their vocabulary, on writing skills, et cetera, to prepare them for school.

Mr. Regula. But my experience in visiting these programs is that the staff were not trained teachers. How do you get some of these goals in literacy without having people with some skills in teaching those subjects?

Ms. Dawson. One of the things that happened in the Head Start Reauthorization Act was an emphasis being placed on performance standards and an emphasis being placed on credentialing. We have a goal, which is statutorily mandated, to increase the number of degreed teachers in early childhood to 50 percent by 2003.

Mr. Regula. That is in the Head Start program?

Ms. Dawson. That is in the Head Start program. At this time, roughly about 40 percent of the teachers are credentialed.

Mr. Regula. What do you think could be done to improve the skills of these students or the young people that are in the Head Start program? What would you do in addition to what is presently being done?

Ms. Dawson. We continue to place an emphasis on quality Head Start programs and learning. One of the things that we are very pleased to see is the early data from our FACES survey--this is a survey that is conducted annually. It is the Head Start Family and Children Experiences Study, and certainly it shows that we are getting good results in terms of quality of learning in the classroom.

Because Congress enacted and appropriated substantial funds over the past few years for Head Start expansion, we have set aside about \$1.6 billion specifically focused on the quality aspects. And so it is a continuing effort to increase the educational component and the learning component of that program.

Mr. Regula. What ages? Do you have an age, a parameter on Head Start?

Ms. Dawson. Head Start now has two components. We have the

Early Head Start program, which is from zero to 3, and Head Start from 4--from 4 to 5. To clarify, Head Start is for ages 3 to 5.

Mr. Regula. Mr. Hoyer.

Mr. Hoyer. Thank you, very much.

HEAD START SERVICES

Welcome, Secretary Dawson. Let me start with Head Start, if I can. How many children are eligible for Head Start in America?

Ms. Dawson. I don't know that I have that number right at hand, that are eligible. Right now, we are serving about 916,000 children in Head Start.

Mr. Hoyer. I understand that Head Start is a program everybody seems to say, it works, and we want to leave no child behind, and we are apparently taking too much of America's money to invest in our children or in other things in America. And my question to you is, what percentage of the children eligible are not getting services in Head Start, a program everybody says works, because we do not have seats for them in America?

Ms. Dawson. We are serving, currently, about 60 percent of the eligible children.

Mr. Hoyer. So 916,000 approximately is 60 percent----

Ms. Dawson. Yes.

Mr. Hoyer [continuing]. Of the eligible children; 60 percent of about 1.4, 1.5 million is 916,000?

Ms. Dawson. That is right.

Mr. Hoyer. In that ballpark?

Ms. Dawson. That is about right.

Mr. Hoyer. That means that about half a million children who are eligible are being left behind; am I correct?

Ms. Dawson. Right now, we don't have funding to support that; that is correct. To clarify, we don't know how many of unserved Head Start-eligible children are being served by other programs.

Mr. Hoyer. Okay. You are in a difficult spot. I don't want to put you in a spot, but I do want to make my points.

Now, a \$125 million increase in Head Start: If the CPI is 2.7 and we give it 2 percent increase, your testimony indicated that we were going to stay even. Presuming we were going to stay even by that seven-tenths of a point being taken care of someplace else, where is that going to be taken care of?

In other words--do you understand my question?

We are getting a 2 percent increase in Head Start. The administration is using a CPI of 2.7 percent. If we assume that the costs of Head Start are going up by 2.7 and they get a 2 percent increase, there is a seven-tenths differential there that needs to be made up somewhere. Are we assuming that is going to be made up? And if so, how?

The Children's Defense Fund, as you know, thinks this budget will result in less children, a lower percentage of children being served. Does the administration believe that is the case, or do you believe that we will stay even with the number of children being served? And if so, how do we make up the seven-tenths of a point difference, assuming that rents,

electricity, teachers' salaries, et cetera, et cetera, are going to go up?

Ms. Dawson. Certainly all of the children who are being served with our programs are not being served solely in Head Start. Where we have really stressed emphasis is to increase services to children in both Head Start and in child care. The \$125 million increase this year that is being requested will assure that we maintain the quality by having the teacher salaries and benefits paid during this year.

Mr. Hoyer. Now, let me pursue that.

Do we agree that \$125 million is 2 percent of the base, of 2001's base, plus 2 percent, is the 2002 budget request?

Ms. Dawson. That is correct.

Mr. Hoyer. Okay.

Now, how are we going to increase teachers' salaries, maintain the number of students and absorb the CPI cost for rent, whatever else the costs are of running a Head Start program, and do what you just said in terms of maintaining or increasing quality teachers' salaries and maintaining seats?

Ms. Dawson. I think certainly if all of the Head Start programs were able to absorb all of the needs that you indicate, then we would certainly have a problem; but that is not going to be the case. There are some programs that will not be able to absorb all of the substantial increases that we received last year, and so this budget reflects sort of the average of understanding about how many dollars will actually be needed for this fiscal year.

HEAD START FUNDING

Mr. Hoyer. If I understand what you just said, there are carry-over funds? Is that what you mean?

Ms. Dawson. There are no carry-over funds, but the funding for this year reflects the base that we had for last year and--
--

Mr. Hoyer. That was the 916,000, plus or minus, children?

Ms. Dawson. For the 916,000 children----

Mr. Hoyer. 916,000 is----

Ms. Dawson. Nine hundred sixteen thousand children.

To ensure that we have the same level of funding, there is 1.4 billion on the entitlement side of Head Start that is going to take care of the fact that we do not have advanced funding as we requested last year.

Mr. Hoyer. I am not sure I understand.

Ms. Dawson. So we have a total of \$6.3 billion, plus \$1.4 billion on the entitlement side of Head Start.

Mr. Hoyer. What did we have last year? Are you saying that we have \$1.4 billion more for Head Start this----

Ms. Dawson. We have the same level of funding.

Mr. Hoyer. Correct.

Ms. Dawson. But we are asking for \$125 million increase to assure that we can maintain and sustain those levels of salary benefits and costs.

Mr. Hoyer. I am not sure I understood the \$1.4 billion in entitlements money. I am not following; maybe others are. I am just----

Mr. Williams. I think she is referring to the advance

appropriation from last year.

Ms. Dawson. Yes.

Mr. Hoyer. So are you saying, what, that money was not spent last year? That is what I asked you about the carry-over. You can't spend it in both years, 2001 and 2002. If we had advanced appropriation for 2002, is what you are saying, of \$1.4 billion--correct?

Ms. Dawson. You can go ahead.

Mr. Williams. I think the total amount of money available this year in 2001 was \$6.2 billion.

Mr. Hoyer. Are you telling me----

Mr. Williams. Including the advanced appropriation, and this year the total amount--in 2002, the total amount available will be \$6.3 billion, the \$125 million increase. So thereal increase, year to year, is \$125 million.

Mr. Hoyer. Okay. That is the point I wanted to make, that the \$1.4 billion is a constraint--or would--when you say, we advance-funded \$1.4 billion last year, that was so we could meet our--whatever our budget numbers were last year that--really nobody ever knew what they were, with all due respect. Mr. Regula didn't know what they were, and his consternation equaled mine, all of us on the Appropriations Committee. What I am trying to get at, there is a net increase of \$125 million in the Head Start budget.

Ms. Dawson. That is correct.

Mr. Hoyer. So the \$1.4 billion sounds nice, but it doesn't really mean anything in terms of services to children on the ground in seats for Head Start. Correct?

Ms. Dawson. That is correct.

HEAD START PERFORMANCE

Mr. Hoyer. I go back to my question, and I will stop with this, and then Mr. Regula can ask a question. I will come back our second round; I have a lot of questions.

I am very interested in this program, as you know. I am very interested in coordinated services, as you probably also know. And I want to see us maximize that, and I will ask a question for--that Mr. Regula may not know. But I mentioned the other day, as an aside, until 1995, there had been no Head Start program cancelled in America for nonperformance, not one in 30 years of Head Start, 1965 to 1995.

Donna Shalala was the first Secretary to say, we are going to meet standards, we are going to have performance and kids are going to get what we promise them, or we are going to shut you down.

How many Head Start programs, if any, did we discontinue last year?

Ms. Dawson. I don't know the exact number.

Mr. Hoyer. But there were some?

Ms. Dawson. But there were definitely some.

Mr. Hoyer. That is a significant step, not because any of us want to shut down Head Start centers, but what we do want to do is make sure that the promise of Head Start is the reality of Head Start for children. And there are some Head Start programs--and Jesse Jackson was here when I made this observation last time--that were simply used, frankly, as

political patronage. They were good programs for adults, but not particularly good programs for children, as you--I don't want to ask you to--I don't want to get you in dutch with the Head Start operators around America, so you don't have to respond to that.

So that is my observation. I think that is accurate. They were, luckily, the very small minority.

HEAD START FUNDING

Now, going back to my question, we have cancelled some that don't. So we are getting programs that work, that we are making sure work, and we are getting results. If we only increase this particular program by \$125 million, which is 2 percent--we talk about a 4 percent increase across the bill, but only 2 percent here.

And, in fact, for Early Head Start, as I understand it, we don't go from 9 to 10, but the budget says we are going to be frozen at 9. Correct?

Ms. Dawson. That is correct.

Mr. Hoyer. So that we will be frozen at the 9 percent of the 2 percent increase, which means that Early Head Start will get squeezed as well.

My only question to you is, how can we maintain a level of services and not lose seats, even though we are only serving 60 percent of the children who are eligible for Head Start; that is to say, who meet the income criteria, come from homes that really need help and that we want to help?

Ms. Dawson. I think I would respond to your question by first of all saying, Congressman Hoyer, that certainly in terms of the need out there, we can all agree that there are not enough Federal Head Start funds to address the full needs of the children who are eligible. However, Head Start received some significant funding increases in the past few years, increases that we believe are certainly good for increasing an expansion of the program. But we also need to focus on stabilizing those programs.

And certainly in the area of Early Head Start, it has grown significantly since 1993, rather 1998, when there were roughly about 37,000, rather 38,000, children served, and we now have about 55,000 children who are served in that Early Head Start arena. This budget certainly will maintain that level, and we do believe that we should focus some of our attention on trying to make sure that these programs are stabilized, that they are really providing the quality that the funding supports.

Mr. Hoyer. Ms. Dawson, again--and maybe I will ask Mr. Williams. It is very difficult for us on this side to really want to put you guys on the griddle who are sort of warming the chairs and not--not the decision-makers. You are a very important person. I don't mean to, but--I understand you are in a difficult spot, but I really--and this is not partisan.

I feel passionately that we have a program that works, and we say--and I agree with the President 100 percent--that we ought to leave no child behind, and we have 40 percent of the kids eligible for this program that we do not serve because allegedly we don't have the resources to do it in the richest nation on the face of the Earth.

And we need to give money back to people. I am for giving money back to people; I am for tax cuts. But I think the premise that we have done everything in America that we need to do when we are not serving 40 percent of the kids eligible for Head Start is bogus. I don't buy it. It is not true. It is not worthy of a great nation. That is my view.

Now, all I am--and I am not asking you to say yea or nay on either--on any of that stuff, but I don't see--and then I will yield, because I have already taken more time than I should have. But I don't see how we can maintain services at a 2 percent increase in a 2.7 percent CPI environment, freeze Early Head Start at 9 percent, notwithstanding the fact, we said it was going to go to 10 percent in the statute, and say that we are doing what we need to do to leave no child behind.

You can't answer that because that is a policy issue, that is a political judgment. But I just want you to know, and then the Department to know, this department is to advocate for children and families. And you cannot do so--if we are not serving them properly, at least we ought to say, we are not doing it. But we don't have the resources to do it; that is an honest answer. I don't mean, to you, not giving me honest answers.

But any event, Mr. Chairman, I will yield. I will come back in the second round.

Mr. Regula. Mr. Wicker.

ROLE OF MS. DAWSON

Mr. Wicker. Thank you. Secretary Dawson and Secretary Williams, are you simply warming the bench today? Did Mr. Hoyer accurately characterize your role?

Ms. Dawson. It feels pretty hot to me.

Mr. Hoyer. Would the gentleman yield? I in no way want to in any way cast aspersions on Diann Dawson, who is an extraordinarily able and conscientious servant. She is, however----

Mr. Wicker. No.

Mr. Hoyer. It is just a political point. That is my point.

Mr. Wicker. No. I just think it is a fair question to--did you have any input whatsoever in the budget request? If you didn't, that is fine. I want to know, but is this totally someone else's budget and you are just here?

Ms. Dawson. This is the administration's budget.

Mr. Wicker. I see. Did you have input in it in the request that was made?

Mr. Hoyer. Mr. Williams is going to save you, the good lawyer that he is.

Mr. Williams. Secretary Thompson was here when this budget was put together, and he helped to negotiate the budget with the Office of Management and Budget. The President has laid out some priorities, both in terms of tax cuts, but also in terms of the amount of spending that he believes is appropriate for discretionary programs in the government, and within those--within that framework, the Secretary set some priorities, and the budget that you see here is a result of that negotiation with the Office of Management and Budget and the President.

Mr. Hoyer. He has been around a long time, Roger.

Mr. Wicker. I really am strapped for time, so I will just leave that.

HEAD START POPULATION

Sixty percent of eligible children, Secretary Dawson, are part of Head Start now, and I think you have gone a long way to answer Mr. Hoyer's questions. I do think we have made great strides in the last 7 years or so in Head Start. There have been significant increases, and I am a fan of Head Start. I feel like I have been a part of a fairly substantial stride forward in this program.

We are not turning 40 percent of the people away, are we, at the door? I mean, some of this is voluntary, is it not?

Have you looked at the 40 percent of eligible children who are not in programs? Are we turning them away, or are there other reasons, and have you studied that?

Ms. Dawson. Certainly there are other preschool programs and child care, and many programs that parents take advantage of that are available there are not just Head Start programs.

The Department of Education funds a number of programs, and certainly, as I say, one of the things that we have been encouraging are full-day, full-year programs with Head Start collaborating with the child care providers. So children are being served in other ways, but other than in Head Start.

Mr. Wicker. All right. Let me just ask one other line of questioning, Mr. Chairman, if I might.

DEVELOPMENTAL DISABILITIES COMPLAINT PROCEDURE

Your agency, I believe, has within its jurisdiction the office of developmental disabilities.

Ms. Dawson. That is correct.

Mr. Wicker. And within that agency, there is a mechanism to have advocacy programs for children in schools who have disabilities; is that correct?

Ms. Dawson. That is correct.

Mr. Wicker. A while back, I sent a letter to that particular office, the Development Disabilities Office. I received a complaint from a school district, not that the advocacy program existed, but that in a particular instance, in one particular instance, the school district thought that the advocate and the counsel had gone too far, had been overzealous.

A hearing--a complaint was lodged against the school district, and an administrative hearing was held. The administrative law judge ruled in favor of the school district, and the advocate, as provided for under the law, took the next step of going to court. But the school district felt that the lawsuit was frivolous.

There is a grievance process that clients may use, that the child may use, or advocates of the child or the parents of the disabled child may use; there does not seem to be any grievance process for the other party, the school district, to simply take to some higher authority. We believe, in this instance, that the lawyer has gone overboard and has gone outside the bounds of what is proper. And I got back a response listing the

grievance procedures that a client may use.

So I would just ask you, do you know--are you able to tell me whether there is a grievance procedure that the other party could use also, or is the school district simply left to complain to the protection and advocacy agency that is actually bringing the action against them? Is there some independent grievance for both sides of an issue?

Ms. Dawson. I think there certainly should be. Frankly, I don't know the full extent of the procedure in the DD program to address your concern, but I will be happy to look into it and get back with you.

Mr. Wicker. Okay. Very well. You will place that on the record, then?

Ms. Dawson. Yes. I will.

Mr. Wicker. That is all I needed.

Thank you very much, Mr. Chairman.

[The information follows:]

Grievance Procedures--Development Disabilities Protection and Advocacy Programs

In a case where a third party (e.g., a school district) has a complaint about the actions of the P&A, they would use the same grievance procedures as a client. Under the case in question, the school district would contact the Executive Director and obtain the grievance procedures. Each State P&A has their own, but typically the Executive Director would forward such a complaint to the Governing Board for resolution.

HEAD START APPLICATIONS

Mr. Regula. Okay. I am curious. It has been pointed out that there are a number, maybe 40 percent of the eligible children, that are not served. How do you get applications? Do the parents call Head Start, or how do you get students? Because in my district, which is an industrial district, they were trying to find kids for the Head Start program. They were making announcements. They didn't--their enrollments were down.

Ms. Dawson. Well, that is an issue in terms of the new dollars that have been funded in fiscal year 2001; we are presently receiving applications now for expansion grantees.

Mr. Regula. Applications from----

Ms. Dawson. From the grantees in terms of the number of children----

Mr. Regula. Like community development.

Ms. Dawson. Community----

Mr. Regula. Community action agencies?

Ms. Dawson. Yes, Some are school administrators.

Mr. Regula. They administer these programs?

Ms. Dawson. Some are nonprofit organizations. Some are certainly CAP agencies.

Mr. Hoyer. Mr. Chairman, about 25 percent of the Head Start programs are run through school systems. The other 75 percent are like community action committees or other agencies that are not school-based. Some, however, have, as you may know, cooperative arrangements with school systems, and although community action agencies run them, they run them at school

sites.

Mr. Regula. Well, yes. In our area, it is the community action agency, it is separate from the school system. But sometimes we play with numbers, and I wonder if there are 40 percent, whatever number it is, of children seeking this help that would not necessarily be getting it; or is it a case, perhaps, that there are not always applicants to run a program?

Ms. Dawson. The 40 percent who are not served are the number that we have who are Head--who are Head Start-eligible but are not being served by Head Start.

Mr. Regula. How do you know if they don't have an applicant? How do you know they are eligible?

Ms. Dawson. We have guidelines about family eligibility.

Mr. Regula. I understand that, but do you survey the community to see if there is this number of children that fit the guidelines?

Ms. Dawson. Yes. We use information from the Census Bureau that tells us a lot about where the populations have shifted and where the need is greatest, and so we then make our announcements targeted toward those populations.

Mr. Regula. Is the key to success, though, getting a good organization to be responsible for the program?

Ms. Dawson. Absolutely.

Mr. Regula. And you don't always have that in every community probably?

Ms. Dawson. We are always seeking to ensure that as we designate the guidelines for expansion, that we are able to target new grantees, as well as make sure that the existing grantees are able to take care of the needs in their community.

Mr. Regula. Do you have to turn down grantees for lack of funds?

Ms. Dawson. For lack of funds, no. No. We have sufficient funds that we have been able to accommodate grantees.

Mr. Regula. So you can respond to all the applicants you get--applications you get?

Ms. Dawson. We have so far been able to do that.

HOURS IN HEAD START

Mr. Regula. What is the average number of hours that children spend in Head Start that are enrolled in a program? Is it a half day, a full day?

Ms. Dawson. From the genesis of the Head Start program, most of the programs were half-day programs, but as I said earlier, we have put a specific emphasis on getting those programs to be full-day, full-year funded, particularly as a result of welfare reform. More parents are working, and there is greater need for those kinds of quality education programs for the children all day, full day, rather to clarify all day full year.

Mr. Regula. What percent of your programs are a result of a school district making the application?

Ms. Dawson. I don't know that I have that in front of me.

Mr. Regula. Well, do you get quite a few applications from school districts to operate the Head Start program?

Ms. Dawson. Yes, we do have quite a few.

HEAD START PARTNERSHIPS

Mr. Regula. Is that increasing? Are more and more school districts recognizing the importance of early childhood education--it would seem school districts would want to encourage this as a precursor to their enrollments in the kindergarten program--and, therefore, would be applicants.

Ms. Dawson. We are seeing a lot of communities that are beginning to do more collaboration with stand-alone Head Start programs in their school districts.

Mr. Regula. Okay.

Ms. Dawson. And certainly we ensure those partnerships.

Mr. Regula. I would think so. The Judy Centers do some of this. Isn't that part of the role of the Judy Centers to coordinate these programs?

Mr. Hoyer. Yes. The whole concept of Judy Centers, as you know, Mr. Chairman, is that, collaboratively put together, different programs; as you said, they are multiple programs that can serve--many serve the same children. And if you pull them together, A, you ought to save money; and B you ought to have a better effect. That is the whole theory of the Judy Center.

Mr. Regula. I think you have a bill to----

Mr. Hoyer. Yes.

Mr. Regula [continuing]. Encourage that.

Mr. Hoyer. We are going to introduce the full-service community school bill, which I have been working on for years, really. Hopefully, by the time we take the break, and then I will sit down with you and others on the committee and go over it.

Mr. Regula. Ms. DeLauro.

EARLY LEARNING OPPORTUNITIES PROGRAM

Ms. DeLauro. Thank you very much, Mr. Chairman. Thank you for being here. Let me just--I have about two or three questions to ask about. Let me just lay this on the line here.

I can't tell you how really upset I am--and it is more than disappointment--really upset about eliminating the Early Learning Opportunities program. Last year we created and funded this program, about \$20 million really, in an effort to address the need for quality child care for the youngest children. I spent a lot of time in trying to deal with those years zero to 3, zero to 5. We have--we could probably--it is more than this table.

We could fill rooms with the information that we have today, scientific information, and as far as I know--I am not a scientist. I don't know about any of my colleagues on this committee, but we have listened to academicians, to scientists, to people who deal with children and learning and how they learn and when they learn. And we know that those years from zero to 3 are the years when you have--the greatest learning exists for our kids; and if you don't utilize those years and teach and provide a kind of child development environment for youngsters, that it is not like you can go back, you can fast-forward 10 years and they can recoup. They can't. Because the neurons and whatever it is because--I am not a scientist, but they tell you that you learn then, and if you don't, you have

missed the opportunity for life.

Now, I think we have some sort of an obligation as public servants, with the volumes of material that we have, to utilize it in the way that we maximize our youngsters' learning potential, because this is the early start. This is where they learn and where they go on to Head Start and to elementary school and so forth. They have been in an environment which then has provided them with the best that we can offer.

And I will be very honest. I have said this about myself, so I would--I think that if we do not utilize the material and the data that we have in this area and act on it, that we ought to--we ought to be held criminally liable, because we know and then we choose not to do anything.

And when we now have seen that this kind of a program, Early Learning Opportunity program, is eliminated, so what are we going to deal with in terms of cognitive, emotional development? And I will tell you that there are the fewest placements in our child care system, or this area, the least qualified people in the area. What we need by way of accessibility, affordability, credibility and credentialing in this area is something that we would be wise to spend our money on.

I might just add that this program that we dealt with for \$20 million was a bipartisan effort to provide parents, child care providers, teachers, other caregivers the support they need in this area.

I am interested to hear your thoughts on why the program was eliminated despite the fact that only 25 grants out of the 300 applicants were able to be funded last year. Does the administration not feel that early learning, quality infant and toddler care are no longer a priority in this country?

Ms. Dawson. I think you will find that this budget, the administration's budget, is a strong budget with the children's interest in mind. The Early Learning Opportunity Fund that you are referring to was funded for the first time in 2001, and this budget request does not request funding beyond last year's level. However, this budget does request \$75 million. So where we have lost the \$20 million in the Reading First Program, the \$75 million is the Reading First Program, which will be administered by the Department of Education where the President chose to demonstrate his commitment toward children in the early learning area.

Ms. DeLauro. And what does that entail, \$75 million?

Ms. Dawson. \$75 million is for the Early Learning First program.

Ms. DeLauro. I know. What is it, though?

As I say, we have put together a pretty solid bipartisan effort in the Early Learning Opportunities that was, you know, vetted, went through all kinds of processes here to--you know, when you are looking at a commitment of this sort, this is leaving a lot of kids behind. This is leaving a lot of kids behind if we can't get to them in those early years.

If somebody can please give me, or get to me, an explanation of why this kind of a program gets eliminated.

We have cut child abuse prevention 18 percent. That is--when we have got the rising statistics of children being abused in this country, and I deal--come from New Haven, Connecticut

where I spend a lot of time with the folks at the Yale Child Center, who witness every single day what is happening to children who are abused. And the statistics keep rising. So that is another area.

But explain to me--not--you don't have to--just lay out, get us something that shows the rationale for cutting back on the Early Learning Opportunities program, if you can. That would be helpful.

Ms. Dawson. Okay.

[The information follows:]

Early Learning Opportunities Program

The Early Learning Opportunities Program was not included in ACF's budget for FY 2002 because the program largely duplicates a new reading program included in the Department of Education's budget at \$75 million.

CHILD CARE AND DEVELOPMENT BLOCK GRANT

Ms. DeLauro. The President's budget increases the Child Care and Development Block Grant by \$200 million this year. However, you have got a proposed set-aside of \$400 million for the after-school certificate program. Now, it looks like there is an increase to the 2.2 number, but if you actually take a look at it, as I understand that, the increase becomes a decrease in funding for basic child care services to the tune of about \$200 million.

I am for after-school programs. I used to teach in the after-school programs in the city of New Haven. I was a volunteer. I taught modern dance and calligraphy many years ago. Haven't done either for a lot of years, not sure I could do either. But we do have the Department of Education's 21st Century Learning Centers. That is a good--you know, an excellent program to deal with after-school programs.

So what I am not trying to do is to say that we shouldn't have the after-school programs; they are critically important. But what we are doing here is that this carve-out in the block grant, in the State grants, would be cut from \$1.9 billion to \$1.7 billion in fiscal 2002.

Again, we are looking at a need these days for core child care services, and for low-income families this need is rising, specifically when you are moving from welfare to work. How does the administration justify taking money from this program at a time when only 12 percent of eligible children are receiving services?

Ms. Dawson. First of all, there is an increase in the Child Care and Development Block Grant of \$200 million. There is also an increase of \$150 million in entitlement funding for child care; so there is a total increase of \$350 million in child care funding.

The \$400 million set-aside that you referred to is the administration's desire to target funding for child care to the older children as well. Those funds are being requested in order to deal with some of the at-risk behaviors of older children.

One of the things that we have learned with some of the evaluations in welfare reform is that while the younger

children seem to be faring well, there are certainly indicators that older children are not doing as well. And so this is an effort in terms of balancing the budget framework to target funding for after school care for adolescents, but at the same time to continue the commitment to provide for child care for the younger children. That funding results in a \$350 million increase in child care, in terms of the Child Care and Development Block Grant, as well as the entitlement funding for child care.

Ms. DeLauro. But it is true that you do take \$200 million out of the child care services and put them into the after-school program.

Ms. Dawson. Well, they are----

Ms. DeLauro. It was 400, but it is 200 from the child care services that are ongoing; and I understand--and I don't have all the details, but I will take a look at it--that \$150 million was previously authorized.

Ms. Dawson. Yes.

Ms. DeLauro. So it is not new. So that is----

Mr. Williams. Ms. DeLauro----

Ms. DeLauro. If you take a look at both discretionary and mandatory, as I understand this, the total funding for core child care services would increase about 8 percent in fiscal year 2002, compared with a 29 percent increase in fiscal year 2001. When you do all the moving--and the moving around and so forth, which is what you want to try to take a good look at, is what we are dealing with in terms of increase versus where we need to go when you have only got 12 percent of kids who are eligible taking advantage of these kinds of services--I am sorry, I didn't mean to----

Mr. Williams. The only thing that I want to put out is the 150 million is new money, though.

Ms. DeLauro. I understand that.

Mr. Williams. It is new resources this year.

Ms. DeLauro. I understand that it was previously authorized, and that is fine, whenever it was authorized. It doesn't make a difference. We will take it wherever it comes from.

And I think we have to be accurate in taking a look at taking 200 out of the child care services, you know, taking that piece and putting it somewhere else. We cannot count twice; we need to count once from whatever we are doing, and then when you take a look overall at both mandatory and discretionary programs, the increase is at a level of 8 percent versus 29 percent in the prior year.

Mr. Williams. I think what we project is that the after-school certificates program would increase the number of kids served by about 500,000 kids, and the younger children that would be served by both the entitlement and the discretionary would stay roughly the same, wouldn't grow, but we would be able to maintain the same levels, but we would serve a lot more kids under the after-school initiative--in the adolescent age.

21ST CENTURY LEARNING PROGRAM

Ms. DeLauro. And what happens to the 21st Century Learning programs? Are they--that is an after-school program? That is

Education?

Mr. Williams. Department of Education.

Ms. DeLauro. Fine. That has been frozen, if you will, in terms of after-school programs from the Department of Education, and I went to visit one of those about a week ago--more than that, about 3 weeks ago.

In terms of a commitment to after-school programs, you know, we need to have consistent commitments to what we are doing and to be able to build on what we do, like the Early Learning Opportunity. I think it is unfortunate that we start things, even things that we know are going well, and now they are cut and are cut in midstream.

Thank you, Mr. Chairman.

JUDY CENTERS--CO-LOCATING PROGRAMS

Mr. Regula. Mr. Hoyer, based on the Judy Centers and the fact you have been on this committee for several years, do you see any potential, prospectively, from combining some of these programs? It seems like, just listening--and I am new to the committee--there is a proliferation of programs that would appear to be duplicative and would result in a lot of money being spent on the administration of a whole group of separate programs.

Mr. Hoyer. Mr. Chairman, I think--I personally think some of that is true.

The administration has an interesting proposal to move Head Start into education--Department of Education. I don't know where that is going to go. There was a big argument in 1965 as to where Head Start belonged, either as an education or as a social services program. Social services won on the theory that young children were not in a learning mode. I think the science on that is substantially changed.

But you are correct in terms of my premise that we have a lot of programs that are designed to serve children and their families, but they are relatively discrete programs and not necessarily coordinated. And as a result, I think they do cost us more, but much more importantly from my standpoint is, they serve the children and families less well than they otherwise could. I have talked to Donna Shalala, Dick Riley and Alexis Herman in particular; but you need to include HUD and you need to include Agriculture for nutrition programs and other programs.

To the extent that we can get the Federal Government to coordinate its programs so that a Judy Center, for instance, which is a multiple service theory for delivery of service to children, including child care, including Head Start services, including education, including family services, including adult literacy, et cetera, et cetera, mostly delivered at school sites, mostly elementary schools which are the only public facilities available in every community. Obviously some are farther away, because the communities are more rural, but the only facility--and the theory was, if you did that, A, you maximized the use of your capital investment; B, you maximized the use of your personnel.

Obviously, custodians, for instance, if you have a separate Head Start facility and a separate school, you need two

custodians, two nutritional services, maybe recreational services duplicated, all those kinds of things, which if you have a school-based Head Start, whether it is run by the school system or run by a community action agency--and I have experience in both. Prince Georges County in Maryland is school-based. Charles County, southern Maryland, they are run by the community action agencies, and they are tri-county agencies, and, you know, there are other counties in Maryland which are county-focused.

So you have a multiplicity of delivery scenarios, and I think that to the extent we could all work together and say--I use, as you have heard me, Sally and John, the two kids, little girl and little boy--we all want to do certain things for them, a lot of things for them. But we have sort of separated out where we have those delivery services.

And what I want--I use my funnel analogy, that you have--you gather from eight agencies, Federal agencies, services that Sally and John ought to get, and the delivery person, the LEA or the community action agency or whatever gets these resources, and Sally and John are advantaged.

Right now, we have a very complicated structure delivered discretely in many respects, and it is my theory that less efficiently, more costly, and I think we need to work on that. And I don't know that there is anybody that doesn't want to work on that, but these services have grown sort of like Topsy. We have a good idea, whether it is Early Head Start, Head Start, Even Start, health programs, literacy programs, Chapter One. I mean, we have just a lot of different programs in Health and Human Services, education in particular, that are not as well coordinated as they could be.

Now, let me tell you, the problem I have with block granting is that usually block granting means, Mr. Chairman, that we take 25 percent off the top for, so-called, what we spend on administration. I don't think, A, we spend that much money; but B, what it is frankly at the Federal level or State level, whoever wants to do it, is an excuse for reducing effort.

I frankly think we need to maintain, as you can hear, maintain and expand effort, but make it much more effective and much more inclusive. And I don't think anybody is opposed to that. It is just very difficult to get to, for all sorts of reasons, not the least of which is the turf questions among the advocacy groups in the community, who all have a vested interest in how the programs are now run, whether they are in LEAs or in community action groups or counties, States, local governments. And that is a very real problem, as you know.

HEAD START MISSION

Mr. Regula. Is it a fair statement that Head Start has moved from a welfare culture to more of an education culture over the past several years? I think probably the initial decision was to put it in the, and I quote, welfare program, because you hope to deal with nutrition, with working with parents to do a better job of parenting, all of which of course is important to the child's development. But it seems to me that what I observe is that it is going more toward education--

--

Mr. Hoyer. No. Mr. Chairman, I refer to it as a social service, not so much welfare.

Ms. DeLauro. It was never meant to be a welfare----

Mr. Hoyer. Well, to the extent Head Start eligibility obviously is needs-based, it has a needs base, but it is a social--it is really social service versus education. That was the argument in 1965, and it was, how do you deal best with getting children, which George Bush the First said, we ought to have every child ready to learn by the time they go to school.

Well, this was one of the components in 1965, that disadvantaged children that did not have exposure to the kinds of services Head Start offers were less able to go to school. So that was really a precursor of that theory, which was, I think--I think we all support. But it was social service versus education, and very frankly, the expertise in the 1960s, and the real expert, Zigler, is----

Ms. DeLauro. From New Haven. Right.

Mr. Hoyer [continuing]. From New Haven.

But the argument was whether or not children could be exposed to an educational experience that early and whether they were ready for it and whether that would be a positive experience; and frankly, the social services side of the argument won that, albeit that is why it is in HHS.

Now, I think with--and Hillary Clinton in particular made a lot of effort in making us all aware of how early children begin to learn--prenatal, effectively. You know, that is why--
--

Mr. Regula. Do you yield?

Mr. Hoyer. Sure. It is your time, sir.

Mr. Regula. I just noted that Mrs. Bush, on this Sunday show, used--included Head Start as part of an education environment; and so it follows up with what you mentioned about Mrs. Clinton.

Mr. Hoyer. I think increasingly the expertise is that learning begins at a much, much earlier stage than we originally thought, and therefore, there is much more discussion about Head Start being a multi--a broader service program than simply a social service program and a child care program, that it is, in fact--needs to be a learning experience.

Let me give you--I have gotten on my soapbox here. One of the problems with Head Start being discrete from public education, because of this theory that they got, is that there is little articulation between, therefore, a Head Start experience and a kindergarten experience. If you have them collocated where the Head Start teacher can talk to the kindergarten teacher and the kindergarten teacher talks to the first grade teacher, there is really a much better opportunity to know what the child's needs are, what the child's experience has been, what the child has gotten, what the child hasn't gotten and needs, than if you have them sort of located at various different sites.

So that is--but I think you are right, and I--Rosa wanted to say something. Clearly, the education component is--I think we are much more aware that children can benefit at much, much earlier ages from an educational experience.

Mr. Regula. Ms. DeLauro?

Ms. DeLauro. Thank you very much, Mr. Chairman.

And, you know, my colleague, Mr. Hoyer, has for years--long before I ever got here, both he and Judy have been real pioneers in this effort, people who have been devoted to making the Head Start experience one that is centered in child development as well as a whole variety of other things. But it was about what the mission of Head Start was all about, which is child development.

And there was extraordinary research in the 1960s that indicated that, you know, kids were hard hit by poverty, poor nutrition, health, education, all of those measures; and they did a pilot program with the OEO. And then they--the legislative history of this program was, when those results were good and positive, they moved on to try to expand the effort.

And I might add Ed Zigler, who was known as the father of Head Start, administered that program in the Nixon administration, so that this is not--again, this is centered in what was viewed to be the best kind of child development effort for our youngsters. The legislative history is that it was intended to function as a comprehensive child development--family support to look at a wide range of problems, so that poor youngsters could go to school, and begin school on a more equal footing as well, as disadvantaged kids.

RELOCATING HEAD START AT THE FEDERAL LEVEL

And I might just add that some of those same people today have really commented on moving Head Start to Education, and that they really believe that the comprehensive nature of the program lends itself to staying where it is in terms of health, mental health, nutrition, the educational needs. They are very, very strong in their views that moving Head Start to the Department of Education would be a bad idea.

I won't regale you here, but we can make available--there are loads of studies that have been done that deal with this issue, and they can be passed on, particularly in terms of early interventions, that deal with----

Mr. Hoyer. Rosa, will you yield?

Ms. DeLauro. I will be happy to yield to my colleague.

Mr. Hoyer. You know, part of the consternation that Judy had and that I have is that we have this argument which is essentially, in my opinion, a zero-sum argument, an either/or argument.

I don't think that argument is particularly valid, and the reason I don't think it is valid, I think both sides are right. It is not a question--the problem with the schools, for instance, is, the principals own the schools and others, child development; others are concerned that if the child is in a school setting, the school is going to own the child and the child is going to be subjected solely to some educational experience which may be much too narrow for that child's needs.

I think that is what Rosa is saying, that is what the argument was; and I happen to agree with that. The school facility, although it is an educational facility, is in fact a community investment, a major community investment; the major investment that most communities make is their school. We are spending now on elementary schools, Prince Georges County,

Maryland, I think between \$12 and \$20 million. On high schools, we are spending in the neighborhood of \$30 million plus. That is a tremendous investment.

Rosa is correct. And it is not so much a problem with locating, in my opinion, Rosa--and in education at HHS, it is; that is the argument. It is presumed that Sally and Johnny don't give a darn about whether it is in the Department of Education or HHS. They don't. And very frankly, the deliverer of service at the local level doesn't particularly care. What--the delivery of service that Sally and Johnny care about is the services getting to them in a way that is coordinated, so they get the biggest result.

We at the Federal level have got a very complicated system, and--Mr. Chairman, you heard me say I introduced legislation for \$500,000, put in a bill 5, 6 years ago to ask us to look at how we coordinate these better; and effectively what I got back was a study which told the locals what they need to do to access money better. And I came back and I lamented the fact that that is what came, that we really didn't say how the pedagogues were going to organize it better so the locals could get it easier, which is what I really think we need to do.

But, Rosa, you and I don't disagree, and I don't disagree with any of those studies. Child development is critical, education is critical, and we need to figure out also how families--mothers, dads, single moms in particular--you know, I used the Jesse Jackson analogy of the child and the mom going to the school and getting multiple services, including employment services, literacy services, et cetera, et cetera, with the child getting education and health and human services, social services, child development services, so that at the end of the day they both leave this institution we call a school and say, boy, this was a great day, Mom and Dad--or Mom and child.

That is the model that I think was Judy's vision. It is the vision I think we ought to have.

We are in a new era. We talk about child care as if it is discrete. It is not. And for the most part, we are developing, where schools are, before and after child care locations that also have services. They are not baby-sitters; they are places where you have recreational, arts, enrichment programs before and after school.

And I think it is an exciting concept if we all get over the fact that we are in competition with one another, when we are not. We ought to be in cooperation with one another.

Mr. Regula. I think that role will grow.

I see we are out of time. We have the agency, the Administration on Aging. Do either of you have any salient questions or comments you want to make?

Mr. Hoyer. Can I make one more comment?

Mr. Regula. You bet.

Mr. Hoyer. The argument where things are will be moot if we don't provide sufficient resources to provide the services.

CONCLUDING REMARKS

Mr. Regula. On that note, we are ready to conclude our hearing. We have had a pretty good panel discussion from up

here.

Ms. Dawson. I should say so.

Mr. Regula. It is a difficult issue, and it--I think it troubles those who do not want a child left behind, how do we get that accomplished? It is a great challenge.

Well, thank you for coming, and we can spend a lot more time, as you well know, but we have to move on to the other side of the ledger and get to the Administration on Aging. So we again thank you.

[The following questions were submitted to be answered for the record:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

Tuesday, May 15, 2001.

ADMINISTRATION ON AGING

WITNESSES

NORM THOMPSON, ACTING PRINCIPAL DEPUTY ASSISTANT SECRETARY
EDWIN L. WALKER, DIRECTOR, OFFICE OF PROGRAM OPERATIONS AND DEVELOPMENT
DENNIS P. WILLIAMS, ACTING ASSISTANT SECRETARY FOR MANAGEMENT AND
BUDGET, OFFICE OF BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Introduction of Witnesses

Mr. Regula. We will start the hearing on the Administration on Aging. Thank you, gentlemen, for coming. And with the demographic changes in our society, your agency gets more important by the day, and with the demographic changes that Steny and I have, it also gets more important.

Right?

Mr. Hoyer. Amen.

Mr. Regula. So we are happy to welcome you. And I see, Mr. Williams, you are going to stick around for this one, too.

Mr. Williams. Yes, sir, a little bit of continuity here.

Mr. Regula. That is great.

Okay, your statements will be made part of the record, and you can proceed as you choose.

Mr. Thompson. Thank you, Mr. Chairman. We appreciate the opportunity to be here this afternoon to discuss with you the President's fiscal year 2002 budget request for the Administration on Aging.

I would like to take this opportunity to welcome you, Chairman Regula, to the distinguished position of chairman of the subcommittee. This Administration looks forward to working with you on issues concerning America's seniors, a population that you have dedicated yourself to serving as chairman of the Older Americans Caucus for many years.

With me today are Mr. Edwin Walker, the Director of the Office of Program Operations and Development with the Administration on Aging; and Dennis Williams, the Deputy Assistant Secretary for Budget with the Department of Health and Human Services.

As you mentioned, my written testimony is being submitted for the record. So in the interest of time and with your permission, I will summarize my testimony.

Summary of Opening Remarks

Mr. Regula. Thank you.

Mr. Thompson. This administration's fiscal 2002 budget requests nearly \$1.1 billion for AoA programs, including \$12 million in increases for core programs to support the aging network. One of the Nation's largest providers of home- and community-based care for the elderly, this network comprises 56 State units on aging, 655 area agencies on aging, 235 Tribal organizations and approximately 29,000 paid and volunteer service providers that, in turn, support the well-being, health and independence of older Americans.

The President's budget for AoA requests \$562 million for nutrition programs to serve over 301 million meals in fiscal 2002, an increase of over 7 million meals. Congregate meals, home-delivered meals and meals to Native Americans are a core component of our Nation's home- and community-based long-term care system, helping America's elderly maintain their health and remain independent.

We are requesting \$327 million for the Supportive Services program. Supportive Services funding allows a community to develop comprehensive and integrated systems to deliver services such as rides to medical appointments, chore services and adult day care.

In addition to programs that directly assist the elderly, AoA now provides assistance to those who care for the elderly. The National Family Caregiver Support Program was established last year in the reauthorization of the Older Americans Act to provide information on available resources, assistance in locating services, caregiver counseling, training and peer support and respite care. On February 15th, Secretary Thompson authorized the release of \$113 million to States to begin the implementation of this important program. For fiscal 2002, our budget requests \$127 million, an increase of \$2 million over fiscal 2001.

The budget request also includes \$17.6 million for Title IV training, research and discretionary projects. Our fiscal 2002 request will continue to fund ongoing activities, such as Senior Legal Hotlines and related elder rights projects, Native American Resource Centers and other minority aging projects, models for preventing health care waste, fraud and abuse and GPRA-related evaluation activities.

We are also asking for a total of \$1.8 million for Pension Counseling and the Eldercare Locator. Preventive Health Services, Protection of Vulnerable Older Americans and Alzheimer's Disease Demonstration Grants are smaller programs that have a big impact on the health and well-being of the Nation's elderly. For these programs our fiscal 2002 request totals \$44 million.

And, finally, our budget requests \$18 million for Federal administration to support 124 full-time equivalents and related expenses. This request will enable AoA to continue to improve services to our customers, expand our information activities

and continue our work on behalf of older Americans.

Along with our fiscal 2002 budget request, we also provided the Committee with our performance report for fiscal year 2000 under the Government Performance and Results Act and our performance plan for this year and next. These documents, Mr. Chairman, reflect a significant improvement over previous years' plans and reports, in large part because of the efforts of States and local area agencies on aging to improve the availability and quality of data. I would like to commend our partners for working with us on this.

Thank you, Mr. Chairman, Mr. Hoyer, for your time. I will be happy to answer any questions you may have.

[The information follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

Mr. Regula. Mr. Hoyer, since you have to leave, if you want to proceed?

Mr. Hoyer. Thank you very much, Mr. Chairman.

Mr. Thompson, I recently was at a nursing home in St. Mary's County and met with Alzheimer's spouses, mainly, in one case, a daughter of an Alzheimer's victim.

You mentioned the Caregiver Support Services Act. It was--it is obviously--I am sure it is not just Alzheimer's patients, but they are particularly burdensome for an individual to care for. Would you, again, give me the statistics in terms of where the funding is for that program and the increase in that program?

Mr. Thompson. Yes, sir. The total appropriation for Caregivers this fiscal year is \$125 million; \$5 million of that was set aside for funds for the Tribal Caregiver Support Program. The act also provides that 4 percent of the funds available to States will be used for competitive grants to demonstrate new techniques for providing caregiver services; 1 percent would be used for projects of national significance. That leaves about \$113 million for grants directly to States. That money was released in February. The request for FY 2002 was \$127 million.

Mr. Hoyer. Now, in terms of--what is the expectation of how that will be used, that \$113 million essentially, in terms of the grants?

Mr. Thompson. The monies are available to States to develop integrated systems of support. The statute lays out five required activities; that is, providing information to caregivers, to assist in access to services, to provide counseling, training, peer support, respite care and then a catchall of supplemental services to deal with other needs.

Mr. Hoyer. Is there a research or a statistical component to this aspect in the sense of assessing the needs, for instance, for respite care?

One of the things that the spouses and, in one case, the daughter, as I said, were very clear on was that there was maybe hourly respite care available, but very--even that was on

a limited scale, and almost no weekend or week sort of respite care. Are we doing an assessment of that need?

Ronald Reagan, I think, is a perfect example of someone who courageously indicated, look, this is a problem and it could happen to anybody. And he was obviously subjected to very good health care for much of his life, if not all of his life. And he luckily, and many of us, would have the resources to handle perhaps respite care and needs, or full-time nurses, around-the-clock nurses; but most people can't because it is so darned expensive.

Do we have an assessment of what the need is? We are doing \$113 million. I am not sure where that figure came from, but I guess it is what we had available.

Mr. Thompson. It is very difficult, I think, to get a handle on the exact nature of the need. In putting the program together, we surveyed States that had caregiver programs in place. We talked widely to State and local agencies and to individuals themselves to try to get some indication of what was needed.

The program is designed to be very flexible. States have considerable flexibility in determining how to spend the funds and what kinds of services to provide within the general statutory framework that I mentioned.

There is research in terms of the efficacy of providing caregiver support. For example, there is a study that indicates that providing early, basic support to caregivers of victims of Alzheimer's, in terms of counseling and peer support, can have the effect of delaying the institutionalization of the Alzheimer's victim for up to a year. So, we think, this is a very important program.

Mr. Hoyer. Statistical information of the savings affected by that would, I think, be important as we determine, you know, if you spend it here, you save it over here.

I quoted--I quote Ted Agnew a lot, Mr. Chairman, which may surprise you. He and I were elected to office, State-level office, at the same time in 1966, and he gave an inaugural address, which was a really good one. In the course of it, he said that the cost of failure far exceeds the price of progress. It is a great line, and I use it all the time, because I think this is an instance where if we allow families to keep not just Alzheimer's, but other patients who require an extraordinary level of care in their homes, or in the patient's home, for a longer period of time, we effect substantial savings in the public sector, whether it is nursing homes which--as you know, 70 percent of the nursing home folks are Medicaid patients, because they buy down until they are eligible.

But I thank you for your answer, but I would like to see maybe an answer as to whether or not you think we have enough information on which to make sound judgments and, if not, whether we are getting such information.

Mr. Thompson. Mr. Hoyer, we are doing that. One of the requirements when States receive this money is that they develop a needs assessment. States are in the process of doing that. They just received funding in February, so we will be getting information---

Mr. Hoyer. Good.

Mr. Thompson [continuing]. On how States are perceiving their needs.

Mr. Hoyer. Thank you, Mr. Thompson.

Thank you, Mr. Hoyer.

STATE MATCH

Mr. Regula. Do the States put any money into these programs? Do they match what the Federal Government does? Do they provide input in different ways to the aging programs?

Mr. Thompson. Absolutely, Mr. Chairman. In our core nutrition programs, the match is basically 15 percent; in our caregiver program, it is 25 percent--75 percent Federal, 25 percent State.

PREVENTIVE HEALTH SERVICES

Mr. Regula. What do you do in preventive health care? I guess this would be basically education. Do you have some programs that are made available, or information made available, through the aging centers on preventive health care techniques?

Mr. Thompson. Absolutely. We have a preventive health or health promotion program. This program is funded at \$21 million. The program provides basic health information in senior centers, at meal sites, and in other locations in the community. The program provides health screening, looking at areas like glaucoma, hypertension, hearing.

Mr. Regula. Right in the centers?

Mr. Thompson. Right in the centers or in the community, and other locations as well. It provides a variety of information.

Out of that \$21 million, \$5 million is specifically available for medication management to help seniors who take a wide variety of medications manage their medications, avoid mistakes.

INFORMATION DISSEMINATION

Mr. Regula. Well, we have a lot of areas, either rural areas or people that simply are not aware of services. How do you reach them, if at all?

Mr. Thompson. Well, we think we are doing a pretty good job reaching them, Mr. Chairman. All of our programs at the State and local level conduct outreach activities. They will hold events in the community, at churches, at malls, other areas where seniors may gather, to get the message out.

We also in the Administration on Aging fund the Eldercare Locator that I mentioned earlier. This is an 800 number where, say, if I am looking for help for my father who lives in Olympia, Washington, I can call the 800 number and say, "He has these conditions" and they can refer me to service providers in that community.

We also make a great deal of information available through the National Aging Information Center, which AOA runs. We respond to telephone inquiries, mail inquiries and e-mail requests for information on aging, as well as we put an awful lot of information on our programs and programs in other

agencies and State and local programs on our Web site.

Mr. Regula. I suspect that seniors are not likely to use that as much as perhaps their grandchildren.

Mr. Thompson. Well, that is correct. We target both the elderly themselves and their family members and caregivers.

VOLUNTEERS

Mr. Regula. Mr. Hoyer asked you about the Family Caregiver Support Program. Do you get a lot of volunteers involved in the program? I think that Meals on Wheels, for example, is carried out by volunteers.

Mr. Thompson. Absolutely. In our--particularly in our senior center programs, in nutrition programs, volunteers are an integral part, an essential part, of operating those programs. There are many, many volunteer activities. And we think that is very important, because not only does it support the programs, but it also gives the elderly an opportunity to become more involved in activities and be more active. And that is good for their long-term health, both mental and physical.

Other programs, the ombudsman program that we run that basically helps folks resolve issues with nursing homes and other care facilities, as well as the pension counseling program, both are staffed in large part by volunteers.

WAITING LISTS

Mr. Regula. I notice in your budget document that you said, on any given day, there are 139,000 elderly on waiting lists for home-delivered meals. Is this a lack of funding to provide the meals or a lack of volunteers to deliver the meals? What is the reason for the inability to meet this need?

Mr. Thompson. Well, the 139,000 figure comes from a 1996 study which indicated that there was--for those folks that were on the waiting list, there was about a 2.7-month delay. That can result from a variety of reasons, including lack of volunteers, delays in expanding coverage to other areas, any of the reasons that you mentioned, sir.

MEDICATION MANAGEMENT

Mr. Regula. I was interested also that you have the program on trying to help people to avoid the difficulty that comes with medications, because they get so many; and it can be confusing and often the medications are at cross-purposes. How do you reach those people that need this kind of help?

Mr. Thompson. Well, one of the more interesting approaches to that is what we call the ``brown bag program,'' wherein folks that come to the senior center are encouraged on a particular day to put all their medications in a brown bag and bring them into the senior center where a doctor or a pharmacist will look at those medications, look for possible drug interactions, work with the person to make sure that he understands the doctor's instructions of when to take the medicine and the dosage and so forth, perhaps look for lesser-cost alternatives to those particular medications, that kind of thing.

So we think that is a particularly innovative program.

Mr. Regula. Seems to me that would be extremely helpful to seniors, because there is a tendency for proliferation of drugs. Everyone looks for the magic bullet that is going to take 20 years off their life.

Mr. Thompson. Absolutely.

Mr. Regula. And it is easy to get confused with it.

Mr. Sherwood, do you have any questions you would like to ask?

Mr. Sherwood. Yes, Mr. Chairman. I am looking for that magic bullet, only maybe 20 ain't a big enough number anymore.

Mr. Regula. They only have the fountain in Florida.

Mr. Sherwood. Not in Ohio?

Mr. Regula. No.

Mr. Sherwood. Mr. Thompson, Bill Farley, the Executive Director of the area agency at home for several of my counties has told me that he supports the President's--the administration's request for increasing the level of in-home services, and I understand that on his waiting list for in-home care, he has almost 150 customers that are receiving no services and nearly 100 others with only partial care, and this is in a fairly small rural area.

Could you describe for me the Federal programs that provide in-home support for the elderly that will help them to stay in their homes?

IN-HOME SUPPORTS

Mr. Thompson. Well, we have several, sir. The Supportive Services program, for example, provides a variety of in-home services, including personal care, assistance with chores, transportation is one of the big elements, helping folks get to shopping, get to medical appointments, things such as that. We have the home-delivered meals program, which brings meals to the home of folks that can't get into a senior center for a meal.

The National Family Caregiver Support Program can provide a range of in-home services to help the caregiver assist the elderly person, to help them remain in their home. Those are examples, sir.

FY 2002 REQUEST

Mr. Sherwood. My brother was a family physician for many years, and we have often discussed how much better elderly people do in their familiar surroundings than if you have to institutionalize them for some reason or another; and the chairman and I were joking about--about aging, and I think the older we all get, the more secure it is to be in familiar surroundings. So I think anything we can do to help elderly people be able to maintain and stay in their own homes, we are certainly gaining.

Do you think that this administration's funding request--do you think you will have what you need to operate with?

Mr. Thompson. Well, we are certainly here to support the administration's funding request. I would---

Mr. Sherwood. Well, we know that.

Mr. Thompson. I would also point out that the Department's request for programs that benefit the aging is increasing by 7 percent this year from \$2.8 billion to \$3 billion, roughly twice that for total domestic discretionary spending.

FUNDING PROCESS

Mr. Sherwood. Now, let me get back to the first part of my question.

These funds--I realize we have the funds in the Federal Government and we have the programs at the local level that operate, but are they, normally, bid programs? How--what is the--give me the process, that this funding comes down to the local level.

Mr. Thompson. Well, I will give you the first part of that, and then I think I will turn the question over to Mr. Walker for the more detailed part.

With most of our programs, the funds are allocated to States by formula, a formula that is contained in the statute. As part of the State plan requirement for our program, States must develop an intrastate funding formula based on various characteristics of local planning areas and allocate the funds in accordance with that. These are basically to area agencies on aging. Area agencies on aging then engage in a variety of mechanisms to either provide services directly or through providers.

Edwin, do you want to----

Mr. Walker. Sure. At the local level, the area agencies subcontract their grant funds to local service providers. In cases where there may not be an adequate number of service providers or the quality of service has not been sufficient or adequate, the area agency may provide that service directly. But the beauty of the program is the fact that seniors participate in the design and the determination of the type of programs needed, so it is a program that is very responsive to the needs at the local level.

Mr. Sherwood. Thank you very much.

PROGRAM FLEXIBILITY

Mr. Regula. It sounds like you really get a great deal of latitude with the agency administration as to how they serve their public. Is that correct?

Mr. Thompson. Yes, sir, that is correct. I think that is one of the beauties of the programs that we operate. The needs of the elderly vary all over the map, and the needs of community also vary, and we think it is important that States and local communities have flexibility to be able to design programs that meet their specific needs.

UNMET NEEDS

Mr. Regula. Do you have any information on the unmet needs? I noticed you look at the demographics of the aging statistics. Our population is going to grow considerably; are we going to be able to meet the challenge?

Mr. Thompson. Well, we are certainly trying to prepare

ourselves to do that. You know, like you, we are concerned about that.

The recent census reported currently, 35 million folks in the U.S., 65 years of age and older; that number is going to increase to 70 million, basically double by the year 2030. So it is very important that we think about the implications both in terms of the Federal response, as well as social response to that. We think we are doing that now.

As I mentioned, the Department's budget includes increases in a variety of programs that benefit the elderly, ranging from biomedical research done by the National Institutes of Health to increases in our core programs. We think, in particular, the response of basic biomedical research and clinical research is critical, because much of the services that are required are driven by things like Alzheimer's disease, diabetes and a variety of infections that plague the elderly, and we are trying to attack that very vigorously.

We are also trying to learn from these programs. For example, the National Family Caregiver Support Program, for us, is a new line of business. Historically, we provided services to seniors directly. With the Caregiver Support Program, we are providing assistance to the caregiver. I point out that in this country, approximately 95 percent of the care that is given to the elderly who need assistance is done by families and friends. Only about 5 percent comes in institutional settings. So we think it is very important to learn how to provide support to caregivers so that they can continue to provide the care and keep people in their homes and in their communities.

REMAINING IN THE COMMUNITY

Mr. Regula. Would it be a fair statement that the result of your programs is that more people are enabled to stay in their homes for longer periods of time before requiring some form of institutionalization?

Mr. Thompson. Absolutely, Mr. Chairman. That is the reason for our programs, to provide a setting for people in their home, in the community, and to keep them there just as long as possible and as long as they feel comfortable remaining there.

COORDINATING WITH OTHER PROGRAMS

Mr. Regula. Well, I am quite sure that--just observing myself that having an aging center where people can go and get companionship is very important to their well-being and to their overall health.

Do you coordinate with the National Institutes of Health? Because, as you pointed out, many programs such as Alzheimer's, which they do research in, have a very direct impact on seniors.

Mr. Thompson. Absolutely, Mr. Chairman. One of the primary purposes and missions of the Administration on Aging is to take the research and the information that is generated by a variety of Federal agencies, the NIH in particular, the National Institute on Aging, the Centers for Disease Control and Prevention, the Substance Abuse Mental Health Services Administration, the Health Resources and Services

Administration, and HCFA.

We take information and the best science from those organizations. We look at it and we package it and try to move it out into our network, out into the mainstream of service delivery, whether it be information on Alzheimer's or any other situation.

That is, what we try to do is to get information out so we can provide the best possible services to these folks.

FEEDBACK FROM AGING NETWORK

Mr. Regula. Do you get feedback--obviously you give, in the aging centers, a lot of latitude on constructing programs that meet the needs of the culture of that community. It would certainly be different in the center of New York City than it would be in some remote, rural area.

Do you get feedback as to what works? What innovative programs have been developed in a given aging center that have been very well received and effective? Do they communicate that to you so you, in turn, can add this--these ideas to the communications you have with the centers?

Mr. Thompson. Yes, sir. We are in constant communication with States and with area agencies, as well as many national organizations that represent them, to learn about best practices, innovative programs that work and so forth.

In addition, we also fund a variety of demonstration projects to test new ideas, evaluate those, figure out what works, and take what works and move it out to the mainstream.

In fact, that is, for example, how the National Family Caregiver Support Program came about. We were funding some demonstration projects. We looked at some States that had very promising approaches to this problem. We decided this was a great idea, worked with the Congress to get it into legislation and made it into a national program.

AGING PROGRAMS IN OTHER COUNTRIES

Mr. Regula. Well, my experience in my own community is that the seniors like these centers very much. I would be curious, is this a phenomenon pretty much of the United States, or do other countries around the world have similar programs for their aging population?

Mr. Thompson. I would refer that one to you, Edwin.

Mr. Walker. We have had a number of other countries come here and study the model that we have. It seems to be a very successful model that works here. Again, it is because of the bottom-up planning that is so incredibly responsive to local communities. And we have seen in other countries that they are beginning to take aspects of our program model and adapt it in their countries.

Mr. Regula. I mean, this is a prototype for the Pentagon when you mentioned the ``bottom-up.''

Mr. Sherwood, do you have any additional questions?

Mr. Sherwood. Yes, I do.

HOME CARE/INSTITUTIONALIZATION

Mr. Thompson, you used a statistic that surprised me. You said that 95 percent of the aging population that needs assistance is, you said, cared for by friends and relatives and family, and only 5 percent is institutionalized.

Mr. Thompson. Yes, sir. That comes from a study--a long-term care study that the Department conducted in 1994, and we believe that statistic is still valid.

Mr. Sherwood. But my anecdotal evidence, that is shocking to me.

Now, do you show everyone--do you assume that everyone over a certain age in those statistics needs care?

Mr. Thompson. I don't believe so, sir. The study looked at care that was actually being provided to the individual. Now, there is a range of care. You know, obviously in a nursing home or other assisted care facility, you are going to have very intensive services. That is one end of the spectrum.

The other end of the spectrum is where an elderly person may need just a few services, maybe some help with chores, cutting the grass, maybe some transportation services. But if you aggregate things across that spectrum, the study found that services that were being provided by family and friends for 95 percent of those who needed assistance.

Mr. Sherwood. What percentage of America's elderly end up in an institution at some time? Anecdotally, the conversation--if you go to a senior citizen center, that is what everyone is worried about; and I have a mother who is 95 and lives alone and is very, very active, but folks worry about those things. And if the amount of people that come to my office looking for help to get in a nursing home or some type of assisted living facility--the 5 percent figure just doesn't ring true to me.

Mr. Walker. The research shows that at any given time, the maximum percentage in an institutional setting, which includes hospitals, would be 15 percent of the elderly. The statistic that---

Mr. Sherwood. How do you define elderly?

Mr. Walker. Well, we have been defining it--according to the Older Americans Act, 60 and over. Much of the data, however, is at 65, so we could break that out for you.

But the additional statistic that Mr. Thompson was referring to is that on a regular basis, only 5 percent of the elderly are in nursing facilities.

REDEFINING ELDERLY

Mr. Sherwood. Would it be--is it time for us to redefine that age? Is that--in other words, you are putting me in a category I don't want to feel that I am in.

Mr. Walker. Perhaps we could refer to ``seasoned'' people instead.

Mr. Sherwood. No, no. But I mean, with better nutrition, better health, less--less of us work at jobs that wear us out physically in our lives, and I am wondering if we are--if we are using relevant numbers anymore.

Mr. Thompson. I think that is an interesting question.

We are looking at the census data that came out recently, and the population over 65 in the past decade increased by about 12 percent. The population age 85 and older increased by

35 percent in the past decade. This just indicates the rapid improvements in longevity that are happening in this country.

That is a very good question. I don't have the answer for you, but I think it is something that needs to be looked at.

Mr. Sherwood. Well, of course I didn't expect an answer, but I wanted to put it on the record that maybe we ought to be thinking about it, because I just think our perception of what is old is changing. Although I spent part of my weekend looking at a very old graveyard, and the people who did live to be old in the early 1800s and late 1700s still lived to be old; there just weren't many of them.

Thanks very much.

Mr. Regula. Well, I think you can join AARP at 50. I believe----

Mr. Sherwood. Frightening thought, Mr. Chairman.

Mr. Regula. Well, I want to turn to the youngest member of this subcommittee, who has probably never even thought about aging.

Mr. Kennedy.

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

Mr. Kennedy. Thank you, Mr. Chairman. The youngest member of this committee, who has the State with the number one oldest population, 85 and older, of any State in the Nation. Rhode Island, number one.

I told you we were number one. You didn't know what I meant.

Given that, I want to dovetail with my colleague's comments on where the caregiving is. It is where the families are, and given that, I want to ask you to comment on the unmet need for caregiver support, given the fact that it is more cost-effective to leverage whatever support we can to support the family in their efforts.

Could you comment on the part of the budget that I should say requests only a modest \$2 million increase, and what support can you provide with a 10 percent increase over last year's appropriated level?

Mr. Thompson. Well, again, we don't have comprehensive statistics on unmet need in this program at this time. I can tell you anecdotally we are hearing that there is tremendous need and desire for help in caring for the elderly. I think many of us have had that experience.

Mr. Kennedy. Yes.

Mr. Thompson. This is a new program. This is the first year that we have been involved in this. The grants just went out in February. We think it is an important step, and we would like to see how this program operates, have States do their needs assessment, get some data that way, and then look at where we go from there.

Mr. Regula. Will you yield?

Mr. Kennedy. Yes.

Mr. Regula. You said the grants just went out in February. To whom or to what agency do these grants go? In other words, who puts this on the ground, who puts it into effect?

Mr. Thompson. We make the grants to the State unit on aging in each of the States and territories.

Mr. Regula. And they, in turn, channel it out to the locals?

Mr. Thompson. Correct.

Mr. Regula. Thank you.

Mr. Kennedy. Well, I can just add my own anecdotal evidence to the fact that especially the BBA cuts, were devastating for visiting nurses programs and the like, which were really supplemented with home care by the families themselves.

And I think we will see--and I would really like to have any evidence that you could provide me, or reports that have been done, in the wake of the BBA cuts, on what the practical effect has been. Because in my State, at least anecdotally, more people have had to become institutionalized because there haven't been the support services needed to keep them in the community. And when we have support services, obviously, in the community--I am not telling you anything you don't already know--you are leveraging the primary caregiver; the family is not getting paid a nickel.

It seems to me if you really want to do things cost-effectively, you support the primary caregiver, who is the family member, and you get a lot bigger bang for your buck. Also you help the people stay where they would like to stay, and that is in the home being cared for by their loved ones. But their loved ones will burn out and burn out quick under the existing, or lack of existing, long-term care or lack of plan, when it comes to taking care of seniors at home.

So to the degree you could get back to me on that, I would appreciate it.

Mr. Thompson. Yes, sir. We will do that.

[The information follows:]

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

NUTRITION PROGRAMS

Mr. Kennedy. And I would be anxious to keep track with you as to how this new program is working. I am sure it is finding itself very needed around the country.

I wanted to get to this fact, that the biggest--single biggest concern I have been hearing from my Department of Elderly Affairs and from my folks back home is just the overwhelming success, but then there comes a double-edged sword here, of the nutrition program. It has been absolutely the hallmark.

I mean, literally, Mr. Chairman, people survive because of this program; they would not otherwise. They rely on the meals they get every day.

One thing that has really bothered me--and I would like you to comment--a recent review of the regulations by OIG would now permit these contributions that the seniors make to the meals, to be used solely to expand or increase services, but not for matching purposes. And the problem I see and what I have heard is, seniors really like to make a small contribution, because they think they are helping the program, and the matching concept is an important concept; and that OIG ruling has

certainly caused great concern for our programs.

Could you comment on that?

Mr. Thompson. Yes, sir. The statute requires that contributions--voluntary contributions made to our programs be used to expand services in the program for which the voluntary contribution was made.

Prior to the reauthorization of the statute late last year, there was perhaps some ambiguity in the statutory language, but with the reauthorization, the language is made very, very specific. As I said earlier, the statute requires the voluntary contributions be used by the local agencies to expand services within the program for which the voluntary contribution was made. We have no flexibility on that.

The intent, of course, is to make those funds available to provide more services. And we would certainly agree that more services are a good thing.

Mr. Kennedy. Well, there's really no more cost-effective program. These meal sites are the survival for many. You come up to my State, and it would just blow you away. The numbers are increasing dramatically. People are relying on these programs of course, with higher utility costs, higher everything costs, prescription costs. Seniors are broke. This is it for them in terms of eating, the budget just doesn't seem to me to be keeping pace with the need, whatsoever.

Do you see the unmet need as growing out there?

UNMET NEED

Mr. Thompson. Well, again, we don't have comprehensive statistical data on that. In discussions with States, with area agencies, with the national organizations, the anecdotal information we get is that, yes, there is unmet need. There are waiting lists in many areas for some of our programs, and the trend seems to be that those waiting lists are growing.

PREVENTIVE HEALTH SERVICES

Mr. Kennedy. Well, we have in Woonsocket, Rhode Island, a 20 percent increase in participation just in the last 5 years. And this has been level funded excluding inflation. So we have level funding for the last 5 years while there has been a 27 percent increase. And because seniors are feeling less financially secure because of their prescription drugs and utilities, they are not making as many contributions; it has really gone down.

So we are at a real break-point in my State, and I can't emphasize enough how important it is for you to make that the hallmark of your Older Americans Act, this meals program.

I have been out, Mr. Chairman, as I would encourage you to go out, with these Meals on Wheels drivers all the time, and your heart would break, as I am sure, if you have ever seen it. You go into these homes, and it is the only contact these people have all day.

The leverage that you, the Federal Government, gets out of this in terms of voluntary services is incredible. This is such a leveraged program.

I know that I have really tried to make my number one

point, and that is, keep working on that and try to figure out ways where we can be more useful in funding that area of your budget.

I would like to go to prevention and how you intend to work to try to incorporate more preventive health service needs into your programs.

Mr. Thompson. Okay. Well, as I mentioned, we have a \$21 million preventive health promotion line item, a separately funded program, that provides health information and screening and other health services in senior centers and other locations in the community.

We also, again, work very closely with the health agencies in the Department to get the best information and the best science from them and get it out to the network to make it available to seniors. These are very important areas for us.

In addition, you know, our core programs--as you mentioned, the meal program----

Mr. Kennedy. Is prevention?

Mr. Thompson [continuing]. Is prevention.

Mr. Kennedy. You bet.

Mr. Thompson. It is providing social contact, improving mental health. It is providing nutrition, which helps keep people healthier and more active.

MENTAL HEALTH

Mr. Kennedy. It is absolutely the hub of all your other social services. They come there. They get their information about what else is going on. They get plugged into all these other programs.

And you mentioned the real key, and that is mental health for many, many seniors. They have lost spouses, they have lost connections to the community; they have been segregated in the community in housing.

Our culture doesn't value senior citizens. It would be depressing to anybody, and it is not surprising that last year the AOA specifically studied older Americans and mental health and found in the report that, quote, ``Approximately 20 percent of Americans 55 or older experienced specific mental disorder in any given year.'' unquote. Mental disorders represent a grave threat to the health and well-being of older Americans.

So given that, what can you say you are doing in the area of mental health services for seniors?

Mr. Thompson. Again, Mr. Kennedy, you have covered a lot of it already. We are doing screenings for mental health, but also the programs themselves are designed to get people into senior centers where they can have both social contact, as well as contact with professionals who can assess need.

In most areas, our home-delivered meals program, for example is not just a matter of you drop the lunch off and run. You are providing social contact. Many of these folks who deliver the meals are trained to recognize signs of mental health or other problems with the individual and to get that information back to the agency so the person can receive the help they need.

Many of our centers are located--collocated with other public service providers so that you can get sort of one-stop shopping with these--for dealing with these situations. And our

caregiver support program is providing help--mental health support in many ways to the caregiver, as well as to the older person.

Mr. Kennedy. How do you coordinate with SAMHSA?

Mr. Thompson. We work very closely with SAMHSA. We have cosponsored conferences with SAMHSA. We have--we want to mention the--yes?

Mr. Walker. Yes. We currently have an effort with SAMHSA to address the needs of older women, and we have placed funding with them in terms of sponsoring a conference and highlighting the issues of older women, particularly the mental health issues.

As Mr. Thompson mentioned, we are coordinating and pushing for the coordination at the local level--State and local level of the mental health network, the primary care network and the aging network for the purpose of better assessing, identifying and then intervening when there are mental health issues identified.

Mr. Kennedy. Well, I would certainly love to learn more about those issues specifically and how the rubber meets the road, because I am finding that there is a huge unmet need, and there is little to no plan to deal with the aging of America and with the mental health needs that they have. In fact, they overutilize the Medicare system because of undiagnosed mental health needs.

Doctors aren't trained. We ought to get more primary care workers in this area to be trained in how to identify mental health disorders, how to treat them, how to get them the support services they need.

So, with that, I look forward to getting some more information, and I certainly appreciate the work that your agency does. It is so vitally important, and I want to make it work even more effectively. So count me in.

Mr. Thompson. Great. Thank you.

Mr. Regula. Well, thank you for coming. I think we have had an excellent discussion here, and it is--I was interested that other countries want to replicate this, because I do think that probably the United States does substantially more for seniors than any other country in the world, and that is a credit to our society that provides the support.

Mr. Kennedy. Mr. Chairman, if I could, we may be doing more, but our culture is not--it does not value seniors the way other cultures do. It is just my experience. I have traveled quite a bit, and I see the way families treat their elders in other places of the world; and believe me, my seniors in Rhode Island don't see their kids. They are all put in these elderly high-rises. It is an absolute disgrace what has happened.

Mr. Regula. Well, it is probably a definition of valuing--how they are valued, and I think it is probably part of our fast-moving society. My grandmother lived with us and, you know, that was a common thing in that day out in the rural areas, the parents would live with their children as they got older.

Today, that is almost a thing of the past. But that is why it is important that we do have these services, and as you have pointed out, and Mr. Sherwood, the Meals on Wheels are their contact with--with society, if you will, or--and a very

important part of it.

Well, you have our blessing, and we will also try to provide some money along with the blessing. Thank you for being here. The committee is adjourned.

[Whereupon, at 4:03 p.m., the subcommittee was adjourned.]

[The following questions were submitted to be answered for the record:]

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